U.S. Department of Labor

Office of Administrative Law Judges
800 K Street, NW, Suite 400-N
Washington, DC 20001-8002

(202) 693-7300
(202) 693-7365 (FAX)

Issue Date: 07 March 2006

In the Matter of

JAMES C. EDWARDS
Claimant

Case No.: 2004 BLA 6398

v.

WESTMORELAND COAL COMPANY
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party in Interest

Appearances: Mr. Ron Carson, Personal Representative
For the Claimant

Ms. Mary Rich Maloy, Attorney
Mr. Christopher M. Hunter, Attorney (on brief)
For the Employer

Before: Richard T. Stansell-Gamm
Administrative Law Judge

**DECISION AND ORDER -
DENIAL OF BENEFITS**

This matter involves a claim filed by Mr. James C. Edwards for disability benefits under the Black Lung Benefits Act, Title 30, United States Code, Sections 901 to 945 ("the Act"), as implemented by 20 C.F.R. Parts 718 and 725. Benefits are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis, or to survivors of persons who died due to pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as "black lung" disease.

Procedural Background

First Claim
(DX 1)[1]

Mr. Edward filed his first application for black lung disability benefits on March 24, 1983. After a pulmonary evaluation, a claims examiner for the U.S. Department of Labor ("DOL") denied his claim for benefits on December 20, 1983 because Mr. Edwards failed to prove the presence of pneumoconiosis or total disability. Through counsel, Mr. Edwards filed a timely appeal on December 27, 1983. Eventually, the case file was forwarded to the Office of Administrative Law Judges ("OALJ") and Administrative Law Judge Giles J. McCarthy conducted a hearing on August 9, 1988. On July 21, 1989, Judge Giles denied Mr. Edwards' claim. According to Judge Giles, Mr. Edwards failed to establish the presence of coal workers' pneumoconiosis and total disability. On August 22, 1989, Mr. Edwards appealed the adverse decision. On July 9, 1991, the Benefits Review Board affirmed Judge Giles' determination that Mr. Edwards did not prove the presence of pneumoconiosis.

Second Claim
(DX 2)

Initial Adjudication

On June 10, 1996, Mr. Edwards filed his second claim for black lung disability benefits. The claim was denied by DOL on March 17, 1997 for failure to prove the presence of pneumoconiosis and total disability. Mr. Edwards appealed on March 26, 1997 and the case was forwarded to OALJ. On November 18, 1997, Administrative Law Judge Ainsworth Brown conducted a hearing. On March 5, 1998, Judge Brown denied Mr. Edwards' claim because the preponderance of the evidence did not establish the presence of coal workers' pneumoconiosis or total disability.

First Modification Request

On January 21, 1999, Mr. Edwards submitted additional medical evidence. However, on March 11, 1999, DOL denied the modification request for failure to show either a mistake of fact or change in condition.

Second Modification Request

On January 21, 2000, Mr. Edwards again submitted additional medical evidence. The modification request was denied on March 17, 2000, Mr. Edwards appealed on April 10, 2000, and the case was forwarded to OALJ in June 2000. Following a November 30, 2000 hearing, Administrative Law Judge Alice Craft denied the modification request on January 21, 2001 for failure to prove coal workers' pneumoconiosis or total disability.

[1]The following notations appear in this decision to identify exhibits: DX – Director exhibit; CX – Claimant exhibit; EX – Employer exhibit; ALJ – Administrative Law Judge exhibit; and TR – Transcript.

Third Modification Request

On February 12, 2002, DOL received Mr. Edwards' third modification request.[2] Since the request had been filed more than one year after the denial of his second modification request, DOL denied the modification as untimely on February 22, 2002. Mr. Edwards appealed the adverse decision on March 15, 2002 and the case was forwarded to OALJ in June 2002. On December 3, 2002, Administrative Edward T. Miller denied the modification request since it was untimely and did not constitute a valid subsequent claim.

Third and Present Claim

On March 13, 2003, Mr. Edwards filed his most recent claim for black lung disability benefits (DX 4). On March 17, 2004, the District Director determined an award of black lung disability benefits was appropriate (DX 27). The Employer appealed on March 23, 2004 (DX 28). After initiating interim benefits on June 2, 2004, the District Director forwarded the case to OALJ on June 9, 2004 (DX 30 and DX 36). Pursuant to a Revised Notice of Hearing, dated March 10, 2005, (ALJ I), I conducted a hearing on March 17, 2005 with Mr. Edwards, Mr. Carson, and Ms. Maloy.

Evidentiary Discussion

At the hearing, an issue was raised concerning the admissibility of the pulmonary evaluations by Dr. Hippensteel (EX 1) and Dr. Castle (EX 3). As part of their examinations, both Dr. Hippensteel and Dr. Castle interpreted a chest x-ray. Based on other submissions by the Employer, these two interpretations exceeded the regulatory evidentiary limitations. As a result, I did not admit their chest x-ray readings.

That evidentiary determination then raised another evidentiary problem. According to 20 C.F.R. § 725.414 (a) (3) (i), each chest x-ray interpretation contained within a medical report must be otherwise admissible. Since the radiographic interpretations of Dr. Hippensteel and Dr. Castle were deemed inadmissible, I was confronted with an objection to admit their medical reports in their entirety. However, on the representation that their review of the record included admissible chest x-rays interpretations consistent with their own interpretations, I admitted the two medical reports (*see* TR, pages 18 to 21). Consequently, my decision in this case is based on the hearing testimony and following documents that were admitted into evidence: DX 1 to DX 36, CX 1 to CX 4, EX 1 to EX 6, EX 10, and EX 11.

[2]Although the cover letter forwarding additional medical evidence to DOL was dated January 7, 2002, the DOL date stamp shows receipt on February 12, 2002.

ISSUES

1. Whether in filing a subsequent claim in March 2003, Mr. Edwards has demonstrated that a change has occurred in one of the conditions, or elements, of entitlement upon which the denial of his most recent, prior claim and related modification requests were based in December 2002.

2 If Mr. Edwards establishes a change in one of the applicable conditions of entitlement, whether he is entitled to benefits under the Act.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Stipulations of Fact

At the March 15, 2005 hearing, the parties stipulated that Mr. Edwards had at least 8 years of coal mine employment; Mrs. Dora Edwards is an eligible dependent for the purposes of augmenting any benefits that may be payable under the Act; and, Westmoreland Coal Company is the responsible operator (TR, pages 41 and 42).

Preliminary Findings

Born on November 6, 1932, Mr. Edwards married Mrs. Dora Edwards on March 22, 1967. Mr. Edwards started mining coal in 1974. Due to breathing problems, Mr. Edwards stopped mining in 1983. At that time, Mr. Edwards was working as a mechanic and repairing belts in the machine shop at the tipple near the mine. Mr. Edwards started smoking cigarettes when he was about 18 and stopped in 1973. He now uses supplemental oxygen (DX 4, DX 9, and TR, pages 28 to 41).

Issue #1 – Change in Applicable Condition of Entitlement

After the expiration of one year from the denial of benefits, the submission of additional material or another claim is considered a subsequent claim and adjudicated under the provisions of 20 C.F.R. § 725.309 (d). That subsequent claim will be denied unless the claimant can demonstrate that at least one of the conditions of entitlement upon which the prior claim was denied ("applicable condition of entitlement") has changed and is now present. 20 C.F.R. § 725.309 (d) (3). If a claimant does demonstrate a change in one of the applicable conditions of entitlement, then generally findings made in the prior claim(s) are not binding on the parties. 20 C.F.R. § 725.309 (d) (4). Consequently, the relevant inquiry in a subsequent claim is whether evidence developed since the prior adjudication would now support a finding of a previously denied condition of entitlement.

The court in *Peabody Coal Company v. Spese*, 117 F.3d 1001, 1008 (7th Cir. 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

To receive black lung disability benefits under the Act, a claimant must prove four basic conditions, or elements, related to his physical condition. First, the miner must establish the presence of pneumoconiosis.[3] Second, if a determination has been made that a miner has pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment.[4] Third, the miner has to demonstrate he is totally disabled.[5] And fourth, the miner must prove the total disability is due to pneumoconiosis.[6]

Based on those four principle conditions of entitlement, the adjudication of a subsequent claim involves the identification of the condition(s) of entitlement a claimant failed to prove in the prior claim and then an evaluation of whether through newly developed evidence a claimant is able to now prove that condition(s) of entitlement. Mr. Edwards' most recent, prior claim was initially denied in January 2001 by Judge Brown for failure to prove the presence of a totally disabling respiratory impairment and pneumoconiosis. The first modification denial and Judge Craft's denial of the second modification request were based on the same rationale – insufficient evidence to prove pneumoconiosis or total disability. Although Mr. Edwards' third modification request was denied on the basis of un-timeliness, the denial procedurally represents a failure to prove any element of entitlement. Consequently, for purposes of adjudicating the present subsequent claim, I will evaluate the evidence developed since the denial of the third modification request in December 2002 to determine whether Mr. Edwards can now prove that he is totally disabled or has pneumoconiosis.

Total Disability

To receive black lung disability benefits under the Act, a claimant must have a total disability due to a respiratory impairment or pulmonary disease. If a coal miner suffers from complicated pneumoconiosis, there is an irrebuttable presumption of total disability. 20 C.F.R. §§ 718.204 (b) and 718.304. If that presumption does not apply, then according to the provisions of 20 C.F.R. §§718.204 (b) (1) and (2), in the absence of contrary evidence, total disability in a miner's claim may be established by four methods: (i) pulmonary function tests; (ii) arterial

[3]20 C.F.R. § 718.202.

[4]20 C.F.R. § 718.203 (a).

[5]20 C.F.R. § 718.204 (b).

[6]20 C.F.R. § 718.204 (a).

blood-gas tests; (iii) a showing of cor pulmonale with right-sided, congestive heart failure; or (iv) a reasoned medical opinion demonstrating a coal miner, due to his pulmonary condition, is unable to return to his usual coal mine employment or engage in similar employment in the immediate area requiring similar skills.

While evaluating evidence regarding total disability, an administrative law judge must be cognizant of the fact that the total disability must be respiratory or pulmonary in nature. In *Beatty v. Danri Corporation. & Triangle Enterprises and Director., OWCP*, 49 F.3d 993 (3d Cir. 1995), the court held that in order to establish total disability due to pneumoconiosis, a miner must first prove that he suffers from a respiratory impairment that is totally disabling separate and apart from other non-respiratory conditions.

The record does not contain sufficient evidence that Mr. Edwards has complicated pneumoconiosis and he has not presented evidence of cor pulmonale with right-sided congestive heart failure. As a result, Mr. Edwards must demonstrate total respiratory or pulmonary disability through pulmonary function tests, arterial blood-gas tests, or medical opinion.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV¹ pre[7] post[8]**	**FVC pre post**	**MVV pre post**	**% FEV¹ / FVC pre post**	**Qualified[9] pre post**	**Comments**
DX 11	May 19, 2003 Dr. Baker	70 67”	1.30	2.73		48%	Yes[10]	Moderate obstruction
EX 1	Jan. 22, 2004 Dr. Hippensteel	71 68”	1.23 1.57	2.20 2.63	29	56% 60%	Yes[11] No	
EX 3	April 21, 2004 Dr. Castle	71 68”	1.15 1.40	2.39 2.43	21	48% 58%	Yes No	
CX 3	June 1, 2004 Dr. Smiddy	71 68”	1.18	2.21		53%	Yes	
CX 4	Sept. 7, 2004 Dr. Smiddy	71 69”	1.58	2.49		63%	No[12]	

[7]Test result before administration of a bronchodilator.

[8]Test result following administration of a bronchodilator.

[9]Under 20 C.F.R. § 718.204 (b) (2) (i), to qualify for total disability based on pulmonary function tests, for a miner’s age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718, **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%. The maximum age on the charts is 71

[10]The qualifying FEV1 number is 1.65 for age 70 and 67″; the corresponding qualifying FVC and MVV values are 2.14 and 66, respectively.

[11]The qualifying FEV1 number is 1.69 for age 71 and 68″; the corresponding qualifying FVC and MVV values are 2.20 and 68, respectively.

[12]The qualifying FEV1 number is 1.79 for age 71 and 69″; the corresponding qualifying FVC and MVV values are 2.31 and 72, respectively.

Under the provisions of 20 C.F.R. § 718.204 (b) (2) (i), if the preponderance of pulmonary function tests qualify under Appendix B of Section 718, then in the absence of evidence to the contrary, the pulmonary tests shall establish a miner's total disability. This regulatory scheme requires a five step process. First, an administrative law judge must determine whether the tests conform to the procedural requirements in 20 C.F.R. § 718.103. Second, an administrative law judge must evaluate any medical opinion that questions the validity of the test results. *See Vivian v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990). Concerning validity, more weight may be given to the observations of technicians who administered the tests than the doctor who reviewed the tracings. *Revnack v. Director, OWCP*, 7 B.L.R. 1-771 (1985). As a result, if an administrative law judge credits the reviewing doctor's opinion over the technician who actually observed the test, he must provide a rationale. *Brinkley v. Peabody Co*., 14 B.L.R. 1-147 (1990). Third, the test results are compared to the qualifying numbers listed in Appendix B to determine whether the tests show total disability. Fourth, a determination must be made whether the preponderance of the conforming and valid pulmonary function tests supports a finding of total disability under the regulation. In that regard, more probative weight may be given to the results of a more recent study over those of an earlier test. *Coleman v. Ramey Coal Co*., 18 B.L.R. 1-9 (1993). Fifth, if the preponderance of conforming tests establishes total disability under the regulation, an administrative law judge then reviews all the evidence of record and determines whether the record contains "contrary probative evidence." If there is contrary evidence, it must be given appropriate evidentiary weight and a determination is then made to see if it outweighs the pulmonary function test evidence that supports a finding of total respiratory disability. *Fields v. Island Creek Coal Co*., 10 B.L.R. 1-19, 1-21 (1987).

The five pulmonary function tests present a conflicting picture as to whether Mr. Edwards has a totally disabling respiratory impairment. Though all the tests appear to be conforming, validity concerns were raised about the May 19, 2003 test. The technician administering the test observed that Mr. Edwards' cooperation was "fair." Dr. John A. Michos, board certified in pulmonary and internal medicine, determined the May 19, 2003 pulmonary function tests were acceptable (DX 12). However, Dr. Joseph J. Renn, board certified in pulmonary disease and internal medicine, reviewed the May 19, 2003 pulmonary function test and noted several deficiencies. Due to Mr. Edwards' failure to maintain "maximal effort" during the entire FVC maneuver, both results for the FEV_1 and FVC were underestimated. Additionally, none of the required three FVC maneuvers was accomplished. Based on these discrepancies, Dr. Renn opined the test was invalid (DX 22). Similarly, upon his review of the May 19, 2003 pulmonary function test, Dr. Hippensteel questioned its validity due to significant variability in Mr. Edwards' effort which understates his true pulmonary function (EX 1).

In resolving this dispute, I first note that the technician who administered the May 19, 2003 pulmonary function test rated Mr. Edwards' efforts as "fair" rather than "good." Next, in validating the test results, Dr. Michos simply checked a box indicating the study was acceptable. In contrast, both Dr. Renn and Dr. Hippensteel provided specific reasoning to support their conclusions that the test was invalid. Such reasoning enhances the probative value of their opinions. Consequently, I find the preponderance of the more probative medical opinion establishes that the test results from the May 19, 2003 pulmonary function test are invalid.

Next, though Dr. Hippensteel noted "small suboptimal tidal waves" associated with the severely decreased MVV result in the January 22, 2004 pulmonary function test (EX 1), I find the remaining four pulmonary function tests are valid. In particular, Dr. Castle considered the April 2004 pulmonary function test and the January 2004 pulmonary function study to be valid (EX 3 and EX 11).

Of the four valid pulmonary function tests, the pre-bronchodilator studies from January 22, 2004, April 21, 2004, and June 1, 2004 met the regulatory qualifications for total disability; whereas, the September 7, 2004 test did not. Thus, the preponderance of valid pulmonary function studies establishes that prior to the administration of inhaled breathing medication Mr. Edwards may be able to establish total disability through pulmonary function test evidence, absent evidence to the contrary.

Other Medical Evidence

As the final step in determining whether the preponderance of the pulmonary function tests establishes total disability, I must consider other recently developed evidence that may be contrary and then render a probative value assessment.

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**pCO^2 (rest) pCO^2 (exercise)**	**pO^2 (rest) pO^2 (exercise)**	**Qualified**[13]	**Comments**
DX 11	May 19, 2003 Dr. Baker	41	63	No[14]	
EX 1	Jan. 22, 2004 Dr. Hippensteel	37.6	69.9	No[15]	Low normal
EX 3	Apr. 21, 2004 Dr. Castle	38.4	68.3	No[16]	

None of the arterial blood gas studies satisfied the regulatory total disability criteria. However, since the pulmonary function tests and arterial blood gas studies measure two different aspects of pulmonary capacity, the non-qualifying arterial blood gas studies, standing alone, do not preclude a finding of total disability based on pulmonary function tests.

[13]Under 20 C.F.R. § 718.204 (b) (2) (ii) (2001), to qualify for Federal Black Lung Disability benefits at a coal miner's given pCO^2 level, the value of the coal miner's pO^2 must be equal to or less than corresponding pO^2 value listed in the Blood Gas Tables in Appendix C for 20 C.F.R. § 718.

[14]For a pCO^2 of 40 to 49, the qualifying pO^2 is 60, or less.

[15]For a pCO^2 of 37, the qualifying pO^2 is 63, or less.

[16]For a pCO^2 of 38, the qualifying pO^2 is 62, or less.

Medical Opinion

When determining whether the medical opinion developed in conjunction with his most recent black lung disability benefits claim represents contrary evidence, I also consider that according to 20 C.F.R. § 718.204 (b) (2) (iv), total disability may be found:

> if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment as described in paragraph (b) of this section.

The regulation, 20 C.F.R. § 718.204 (b) (1) defines such employment as either his usual coal mine work or other gainful employment requiring comparable skills. Thus, to evaluate total disability under these provisions, an administrative law judge must compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of his respiratory impairment. *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993).

Based on Mr. Edwards' testimony about his last coal mining job working as a mechanic, I find he occasionally engaged in moderate manual labor. With that physical requirement in mind, I turn to the opinion of the physicians who evaluated Mr. Edwards' pulmonary condition during the development of this present claim.

Dr. Glenn R. Baker
(DX 11)

On May 19, 2003, Dr. Baker, board certified in pulmonary disease and internal medicine,[17] conducted a pulmonary evaluation. Mr. Edwards had mined coal and worked as a coal mine mechanic for about nine years. From the age of 18 until about 1968, Mr. Edwards smoked cigarettes for about 18 years at the rate of a pack per day. He complained about long-term shortness of breath and wheezing.

Upon physical examination of the chest, Dr. Baker found no abnormalities. The chest x-ray was positive for pneumoconiosis. The pulmonary function test indicated the presence of a moderate obstructive defect. The arterial blood gas study showed moderate resting hypoxemia. Based on the chest x-ray and Mr. Edwards' work history, Dr. Baker diagnosed coal workers' pneumoconiosis. His history of cough and wheezing also supported a diagnosis of chronic bronchitis attributable to coal dust and cigarette smoke. Mr. Edwards also had COPD (chronic obstructive pulmonary disease) due to cigarette smoke and coal dust. The pulmonary function test established that Mr. Edwards was totally disabled. This moderate impairment was due to both his exposure to coal dust and cigarette smoking.

[17]I take judicial notice of Dr. Baker's board certification and have attached the certification documentation.

Dr. Kirk E. Hippensteel
(EX 1, EX 4, and EX 10)

On January 22, 2004, Dr. Hippensteel, board certified in pulmonary disease and internal medicine, evaluated Mr. Edwards' pulmonary condition. Mr. Edwards had worked nine years in coal mining before stopping due to shortness of breath. His work as a coal mine mechanic required intermittent heavy manual labor. He smoked cigarettes for about 15 years at the rate of a pack per day; he quit smoking 35 years ago. Mr. Edwards had been prescribed breathing steroids and used supplemental oxygen a few hours a day. Dr. Hippensteel also reviewed other medical records, including Dr. Baker's May 2003 examination.

Upon physical examination, Dr. Hippensteel heard mild wheezes. The chest x-ray was negative for pneumoconiosis. The arterial blood gas study was low normal. During the pulmonary function tests, Mr. Edwards used suboptimal effort. Nevertheless, his obstructive pulmonary disease showed significant reversibility with bronchodilators. The test also indicated a problem with air trapping. Based on his review and examination, Dr. Hippensteel diagnosed asthmatic bronchitis. There was no radiographic evidence of coal workers' pneumoconiosis and the demonstrated reversibility in the pulmonary function test was inconsistent with pneumoconiosis. The improvement with bronchodilators and Mr. Edwards' prescribed steroids were indicative of an asthmatic condition. His significant obstructive impairment would preclude his return to coal mining from a pulmonary perspective.

In November 2004, Dr. Hippensteel reviewed the medical evidence and pulmonary evaluations developed in 2002 and Dr. Wiot's negative interpretation of the January 22, 2004 chest x-ray. Mr. Edwards' medical history, clinical findings, and in particular, periodic variations in the pulmonary function tests were consistent with his diagnosis of asthmatic bronchitis. Although Mr. Edwards' pulmonary function tests were occasionally normal, the more recent studies showed a worsening condition, suggestive of asthmatic bronchitis which was not related to coal dust exposure.

In a February 28, 2005 deposition, Dr. Hippensteel further explained his evaluation of Mr. Edwards' pulmonary condition. Dr. Hippensteel had reviewed numerous pulmonary evaluations since 1997 and Dr. Castle's most recent evaluation from April 2004. Mr. Edwards had indicated that his last job in the coal mines as a welder required him to lift no more than 50 pounds. He used a crane to lift anything heavier. At the time of his January 2004 pulmonary examination, Mr. Edwards was taking allergy medication and a pulmonary steroid; he also used bronchodilators. Dr. Hippensteel noted that of the five most recent pulmonary function tests, only he and Dr. Castle had conducted a post-bronchodilator test. This test is important to assess the degree of reversibility associated with the airways obstruction. Measurable reversibility "is very indicative of asthma as a condition which is not associated with diseases like coal workers' pneumoconiosis." Since coal workers' pneumoconiosis is a fixed and irreversible impairment, a bronchodilator response is not indicative of pneumoconiosis. In Dr. Hippensteel's test, Mr. Edwards' FVC improved 20% after use of a bronchodilator. In Dr. Castle's tests, a 28% improvement in FEV_1 was noted. Mr. Edwards has a significant pulmonary impairment that has worsened over time. He is totally disabled from coal mine employment due to bronchial asthma which is unrelated to his exposure to coal dust.

Dr. James R. Castle
(EX 3 and EX 11)

On April 21, 2004, Dr. Castle, board certified in pulmonary disease and internal medicine, conducted a pulmonary evaluation. Mr. Edwards had nine years of coal mining before he left due to breathing problems. His last mining job as a machinist "did not involve much heavy labor." He had a cigarette smoking history of 17 pack years.[18] Mr. Edwards complained about chronic shortness of breath, productive cough, and reactive wheezing.

During the physical examination, Dr. Castle heard decreased breath sounds. The radiographic evidence was negative for pneumoconiosis. The arterial blood gas study was normal. The pulmonary function testing showed a moderate, significantly reversible airways obstruction. In his review of the medical record, which included the recent pulmonary evaluations by Dr. Baker and Dr. Hippensteel, Dr. Castle noted Mr. Edwards' occasional reference to childhood asthma and periodic treatment for bronchial asthma. Based on his review and examination, and due to the notable reversibility in the pulmonary function tests, Dr. Castle diagnosed a moderate airways obstruction consistent with asthmatic bronchitis. No clinical evidence existed to support a finding of coal workers' pneumoconiosis. Even if radiographic evidence of coal workers' pneumoconiosis existed, Dr. Castle noted the absence of any physiological changes consistent with pneumoconiosis. Mr. Edwards has a significant and totally disabling pulmonary impairment attributable to bronchial asthma.

In a March 1, 2005 deposition, Dr. Castle again reviewed his assessment of Mr. Edwards' pulmonary difficulties. Prior to the deposition, Dr. Castle had reviewed additional radiographic and medical test results from 2004. At the time of his 2004 examination, Mr. Edwards complained about chronic shortness of breath, occasional wheezing and productive cough. The episodic nature of his complaints are consistent with asthma. Mr. Edwards' reported cigarette smoking histories were varied. In a 2002 examination, he reported smoking cigarettes for 30 years. Most recently, he reported only 15 to 17 years of cigarette smoking. Mr. Edwards' allergy issues are also supportive of an asthma diagnosis since the two conditions tend to "run together." Dr. Castle disagreed with Dr. Baker's diagnosis, noting Dr. Baker did not conduct a post-bronchodilator pulmonary function test. This study helps identify the cause of the airways obstruction by indicating whether the condition is reversible. Dr. Castle also observed that even the pre-bronchodilator results varied from test to test. The pulmonary function tests also showed normal diffusion values which helps exclude pulmonary emphysema as a cause of Mr. Edwards' obstruction. Since emphysema destroys the air sacs, it diminishes the diffusion values. In Castle's opinion, Mr. Edwards is totally disabled due to bronchial asthma, which is not related to coal dust exposure. Mr. Edwards does not have coal workers' pneumoconiosis.

Discussion

For diverse reasons, Dr. Baker, Dr. Hippensteel, and Dr. Castle agree that Mr. Edwards' is totally disabled from a respiratory perspective.

[18]A pack year equals the consumption of one pack of cigarettes per day for one year.

Summary

The preponderance of the valid pre-bronchodilator pulmonary function tests meets the regulatory standard for total disability. The arterial blood gas studies do not represent probative contrary evidence and the medical opinion consensus supports, rather than refutes, a finding of total disability. Consequently, through the preponderance of conforming valid, probative pulmonary function tests, Mr. Edwards has proven total disability under 20 C.F.R. § 718.204 (b) (2) (i).

Correspondingly, based on the preponderance of the valid pulmonary function tests recently developed, Mr. Edwards has shown a material change in conditions by establishing an element of entitlement previously adjudicated against him in his prior claim. As a result, under 20 C.F.R. § 725.309 (d), denial of his subsequent claim based is no longer appropriate. Instead, I will review the entire record to determine whether Mr. Edwards is able to prove all four elements necessary for entitlement of benefits under the Act; thereby establishing that he is totally disabled due to coal workers' pneumoconiosis. As previously mentioned, during this process, according to 20 C.F.R. § 725.309 (d) (4), "no finding made in connection with the prior claim . . . . shall be binding on any party in the adjudication of the subsequent claim."

Issue # 2 – Entitlement to Benefits

Again, to establish entitlement to black lung disability benefits under Act, Mr. Edwards must prove: a) the presence of pneumoconiosis; b) pneumoconiosis related to coal mine employment; c) total pulmonary disability; and, d) total disability due to coal workers' pneumoconiosis.

Pneumoconiosis

"Pneumoconiosis" is defined as a chronic dust disease arising out of coal mine employment.[19] The regulatory definitions include both clinical or medical, pneumoconiosis, defined as diseases recognized by the medical community as pneumoconiosis, and legal pneumoconiosis, defined as "any chronic lung disease arising out of coal mine employment."[20] The regulation further indicates that a lung disease arising out of coal mine employment includes "any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment."[21] As courts have noted, under the Act, the legal definition of pneumoconiosis is much broader than medical pneumoconiosis. *Kline v. Director, OWCP*, 877 F.2d 1175 (3d Cir. 1989).

According to 20 C.F.R. § 718.202 (2001), the existence of pneumoconiosis may be established by four methods: chest x-rays (§ 718.202 (a)(1)), autopsy or biopsy report (§ 718.202

[19]20 C.F.R. § 718.201 (a).

[20]20 C.F.R. §§ 718.201 (a)(1) and (2).

[21] 20 C.F.R. § 718 (b).

(a)(2)), regulatory presumption (§ 718.202 (a)(3)),[22] and medical opinion (§ 718.202 (a)(4)). Since the record does not contain sufficient evidence that Mr. Edwards has complicated pneumoconiosis, and he filed his claim after January 1, 1982, a regulatory presumption of pneumoconiosis is not applicable. In addition, he has not submitted a biopsy report and the record obviously does not contain an autopsy report. As a result, Mr. Edwards will have to rely on chest x-rays or medical opinion to establish the presence of pneumoconiosis. Additionally, under the guidance of *Compton*,[23] I must consider the chest x-ray evidence and medical opinion together to determine whether a claimant can establish pneumoconiosis.

Chest X-Rays

The following table summarizes all chest x-ray interpretations admitted into evidence:

Date of x-ray	**Exhibit**	**Physician**	**Interpretation**
February 1, 1983	DX 1	Dr. Felson, B[24]	Completely negative.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomata present.
(same)	DX 1	Dr. Navani, BCR, B	(Negative for pneumoconiosis);[25] left lobe pneumonitis present.
February 7, 1983	DX 1	Dr. Felson, B	Completely negative.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomata present.
(same)	DX 1	Dr. Saha	(Negative for pneumoconiosis); resolving densities.
February 22, 1983	DX 1	Dr. Gayler, B	Negative for pneumoconiosis; infiltrate left lower base present.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis.

[22]If any of the following presumptions are applicable, then under 20 C.F.R. § 718.202 (a)(3) (2001), a miner is presumed to have suffered from pneumoconiosis: 20 C.F.R. § 718.304 (2001) (if complicated pneumoconiosis is present, then there is an irrebuttable presumption that the miner is totally disabled due to pneumoconiosis); 20 C.F.R. § 718.305 (2001) (for claims filed before January 1, 1982, if the miner has fifteen years or more coal mine employment, there is a rebuttable presumption that total disability is due to pneumoconiosis); and 20 C.F.R. § 718.306 (2001) (a presumption when a survivor files a claim prior to June 30, 1982).

[23]*See Island Creek Coal Co. v. Compton*, 211 F.3d 203 (4th Cir. 2000).

[24]The following designations apply: B – B reader, and BCR – Board Certified Radiologist. These designations indicate qualifications a person may possess to interpret x-ray film. A "B Reader" has demonstrated proficiency in assessing and classifying chest x-ray evidence for pneumoconiosis by successful completion of an examination. A "Board Certified Radiologist" has been certified, after four years of study and examination, as proficient in interpreting x-ray films of all kinds including images of the lungs.

[25]Since a physician evaluating a chest x-ray can be expected to accurately report the presence of any abnormalities, an administrative law judge may infer that the absence of a mention of pneumoconiosis indicates pneumoconiosis was not present. *See Marra v. Consolidation Coal Co.* 7 BLR 1-216, 1-219 (1985).

(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomata present.
(same)	DX 1 & DX 2	Dr. Westerfield, BCR, B[26]	(Negative for pneumoconiosis); small reticular linear changes left base and hilar granulomatous calcifications present.
February 28, 1983	DX 1	Dr. Gayler, B	Negative for pneumoconiosis; pneumonia left base present.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis; infiltrate left base present.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 1 & DX 2	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion category 1/0,[27] type q/t opacities.[28]
April 11, 1983	DX 1	Dr. Gayler, B	Negative for pneumoconiosis; infiltrate left base present.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomata present.
(same)	DX 1	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
May 17, 1983	DX 1	Dr. Pennington, B	Completely negative
July 14, 1983	DX 1	Dr. Cooper	(Positive for pneumoconiosis) "Scattered pulmonary opacities as previously described. . .no significant change since 4-11-83." (referencing Dr. Westerfield's positive interpretation)
(same)	DX 1	Dr. Gayler, B	Negative for pneumoconiosis; linear fibrosis present.
(same)	DX 1	Dr. Morgan, B	Negative for pneumoconiosis; scarring left base present.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomata present.

[26]I take judicial notice of Dr. Westerfield's board certification and have attached the certification documentation. The OALJ website also indicates that Dr. Westerfield was a B reader.

[27]The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1 / 2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Or, a reading of 0/0 means the doctor found no, or few, opacities and didn't see any marks that would cause him or her to seriously consider category 1. According to 20 C.F.R. § 718.102 (b), a profusion of 0/1 does not constitute evidence of pneumoconiosis.

[28]There are two general categories of small opacities defined by their shape: rounded and irregular. Within those categories the opacities are further defined by size. The round opacities are: type p (less than 1.5 millimeter (mm) in diameter), type q (1.5 to 3.0 mm), and type r (3.0 to 10.0 mm). The irregular opacities are: type s (less than 1.5 mm), type t (1.5 to 3.0 mm) and type u (3.0 to 10.0 mm). JOHN CRAFTON & ANDREW DOUGLAS, RESPIRATORY DISEASES 581 (3d ed. 1981).

July 25, 1983	DX 1	Dr. Hauser, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Navani, BCR, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wiot, BCR, B	Completely negative.
October 20, 1983	DX 2	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion 1/0, type q/t opacities.
February 16, 1984	DX 2	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion 1/0, type q/t opacities.
March 28, 1984	DX 1	Dr. Cunningham, B	Negative for pneumoconiosis.
(same)	DX 1	Dr. Wiot, BCR, B	Completely negative.
(same)	DX 1	Dr. Spitz, BCR, B	Negative for pneumoconiosis.
August 14, 1984	DX 2	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
December 13, 1984	DX 2	Dr. Westerfield, BCR, B	(Positive for pneumoconiosis)/small opacities all four lung zones.
March 28, 1985	DX 2	Dr. Westerfield, BCR, B	(Positive for pneumoconiosis)/mild pneumoconiosis changes. Stable chest.
August 1, 1985	DX 2	Dr. McMurry	(Negative for pneumoconiosis). Linear scarring left lung base.
August 6, 1986	DX 2	Dr. Westerfield, BCR, B	(Positive for pneumoconiosis)/stable chest. Old changes; no acute lung disease.
February 11, 1987	DX 1 & DX 2	Dr. Westerfield, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type q/t opacities.
March 16, 1987	DX 1	Dr. Navani, BCR, B	(Negative for pneumoconiosis) Clear lung fields.
October 6, 1987	DX 1	Dr. Saba, BCR, B	Negative for pneumoconiosis; infiltrate lower left lung.
(same)	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; granulomas present.
(same)	DX 1	Dr. Scott, BCR, B	Negative for pneumoconiosis; pneumonia present.
November 1, 1987	DX 1	Dr. Carter	(Negative for pneumoconiosis) Normal chest
November 22, 1987	DX 1	Dr. Saha	(Negative for pneumoconiosis) No cardiopulmonary disease present.
March 1, 1988	DX 1	Dr. Navani, BCR, B	(Negative for pneumoconiosis) No acute disease present.
March 14, 1988	DX 1	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; calcified granulomas present.
(same)	DX 1	Dr. Scott, BCR, B	Negative for pneumoconiosis; small granulomas present.
(same)	DX 1	Dr. Saba, BCR, B	Completely negative.
March 21, 1988	DX 1	Dr. Navani, BCR, B	(Negative for pneumoconiosis) Left infiltrate present.
August 9, 1989	DX 2	Dr. Smiddy	(Negative for pneumoconiosis)[29] Old interstitial lung scarring.

[29]Although Dr. Smiddy long believed Mr. Edwards had pneumoconiosis, his chest x-ray interpretation does not support a diagnosis of pneumoconiosis until March 6,1990, when he first specifically relates the observed interstitial lung disease to pneumoconiosis. After March 6, 1990, I treat his subsequent references in later interpretations to old interstitial fibrosis to be pneumoconiosis.

March 6, 1990	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Interstitial markings consistent with pneumoconiosis.
March 5, 1991	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old chronic changes, basilar scarring, fibrotic area left base present.
March 17, 1991	DX 2	Dr. Saha	(Negative for pneumoconiosis) Small granulomas present.
September 4, 1991	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Resolved pneumonia.
December 3, 1991	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Interstitial markings present
January 31, 1992	DX 2	Dr. Saha	(Negative for pneumoconiosis) Mild emphysema present.
November 12, 1992	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old interstitial scarring.
May 11, 1993	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) No acute process present.
December 9, 1993	DX 2	Dr. Smiddy	(Positive for pneumoconiosis)
March 3, 1994	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old granulomatous changes present.
August 30, 1994	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Basilar fibrosis, COPD present.
February 28, 1995	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old scarring and fibrosis present.
March 7, 1996	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old scarring and fibrosis present.
July 26, 1996	DX 2	Dr. Paranthaman	Negative for pneumoconiosis.
(same)	DX 2	Dr. Cole, BCR, B	Negative for pneumoconiosis.
December 28, 1996	DX 2	Dr. Cassedy	(Negative for pneumoconiosis) Scattered areas of infiltrates left lung base present.
(same)	DX 2	Dr. Dahhan, B	Completely negative.
January 16, 1997	DX 2	Dr. Sargent	Negative for pneumoconiosis.
(same)	DX 2	Dr. Shipley, BCR, B	Negative for pneumoconiosis; focal scarring left base present.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands left base present.
(same)	DX 2	Dr. Castle, B	Negative for pneumoconiosis; calcified granulomas present.
March 11, 1997	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Old interstitial lung disease, “following pneumoconiosis.”
September 21, 1997	DX 2	Dr. Dahhan, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Spitz, BCR, B	Completely negative.
December 28, 1997	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Dahhan, B	Completely negative.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands present.
(same)	DX 2	Dr. Meyer, BCR, B	Negative for pneumoconiosis; linear fibrosis left lung base present.

January 16, 1998	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Dahhan, B	Completely negative.
(same)	DX 2	Dr. Cassedy	(Negative for pneumoconiosis) linear density present, lungs otherwise clear.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands present.
(same)	DX 2	Dr. Meyer, BCR, B	Negative for pneumoconiosis; linear fibrosis left lung base present.
March 11, 1998	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Interstitial lung disease.
July 9, 1998	DX 2	Dr. Smiddy	Pneumoconiosis and emphysema present.
January 5, 1999	DX 2	Dr. Smiddy	Coal workers' pneumoconiosis, emphysema and old chronic scarring present.
February 5, 1999	DX 2	Dr. Hippensteel, B	Negative for pneumoconiosis; calcified hilar nodes.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; calcified granuloma present.
(same)	DX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; emphysema present.
February 13, 1999	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Dahhan, B	Completely negative.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Meyer, BCR, B	Negative for pneumoconiosis; linear fibrosis left lung base present.
February 22, 1999	DX 2	Dr. Smiddy	Pneumoconiosis, emphysema and new pneumonia left base present.
March 8, 1999	DX 2	Dr. Smiddy	(Positive for pneumoconiosis) Clearing infiltrates left base from film of Feb. 22, 1999.
March 17, 1999	DX.2	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type p/s opacities; emphysema present.
April 30, 1999	DX 2	Dr. Dahhan, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands present.
(same)	DX 2	Dr. Kim, BCR, B	Negative for pneumoconiosis; small calcified granulomata present.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; linear scar at lung bases.
(same)	DX 2	Dr. Meyer, BCR, B	Negative for pneumoconiosis; calcified granulomas present.
February 29, 2000	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; small calcified granulomata present.
(same)	DX 2	Dr. Dahhan, B	Completely negative.
(same)	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.

(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; linear strands at lung bases.
(same)	DX 2	Dr. Meyer, BCR, B	Negative for pneumoconiosis; linear fibrosis.
January 15, 2001	DX 2	Dr. Hippensteel, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Castle, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; calcified granuloma present.
(same)	DX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; COPD (chronic obstructive pulmonary disease) present.
(same)	DX 2	Dr. Smiddy	(Positive for pneumoconiosis); old pneumoconiosis and emphysema present.
February 20, 2001	DX 2	Dr. Hippensteel, B	Negative for pneumoconiosis; minimal infiltrate present.
(same)	DX 2	Dr. Castle, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; calcified granuloma present.
(same)	DX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; emphysema present.
September 1, 2001	DX 2	Dr. Hippensteel, B	Negative for pneumoconiosis; small infiltrate left base present.
(same)	DX 2	Dr. Castle, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis; emphysema present.
(same)	DX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis; emphysema present.
June 11, 2002	DX 21	Dr. Pathak, BCR, B	Positive for pneumoconiosis, profusion category 2/2, type p/q opacities. Emphysema present.
(same)	DX 21	Dr. Miller, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type p/t opacities. Emphysema present.
(same)	EX 5	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
August 28, 2002	DX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis; calcified granulomas present.
(same)	DX 2	Dr. Spitz, BCR, B	Negative for pneumoconiosis; calcified granulomas present.
(same)	DX 2	Dr. Shipley, BCR, B	Completely negative.
(same)	DX 2	Dr. Wheeler, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scott, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Scatarige, BCR, B	Negative for pneumoconiosis.
(same)	DX 2	Dr. Castle, B	Negative for pneumoconiosis, profusion category 0/1, type s opacities.
May 19, 2003	DX 11	Dr. Baker, B	Positive for pneumoconiosis, profusion category 1/0, type t/s opacities.

(same)	DX 23	Dr. Wiot, BCR, B	Negative for pneumoconiosis; calcified granuloma at right apex present.
January 22, 2004	CX 2	Dr. Alexander, BCR, B	Positive for pneumoconiosis, profusion category 1/0, type r opacities; calcified granuloma right apex present.
(same)	EX 2	Dr. Wiot, BCR, B	Negative for pneumoconiosis.
April 21, 2004	CX 1	Dr. Ahmed, BCR, B	Positive for pneumoconiosis, profusion category 1/1, type s/t opacities.
(same)	EX 6	Dr. Wiot, BCR, B	Negative for pneumoconiosis.

The radiographic record of more than twenty years contains 63 images of Mr. Edwards' chest. The respective interpretations for most of the individual films were undisputed. For these chest x-rays, due to the absence of any contrary interpretation, either the sole opinion or consensus of all the physicians to review a particular film established whether it was positive or negative for pneumoconiosis. Consequently, the following 30 chest x-rays are negative for the presence of pneumoconiosis: February 1, 1983, February 7, 1983, February 22, 1983, May 17, 1983, July 25, 1983, March 28, 1984, August 1, 1985, March 16, 1987, October 6, 1987, November 1, 1987, November 22, 1987, March 1, 1988, March 14, 1988, March 21, 1988, August 9, 1989, March 17, 1991, January 31, 1992, July 26, 1996, December 28, 1996, January 16, 1997, September 21, 1997, December 28, 1997, January 16, 1998, February 5, 1999, February 13, 1999, April 30, 1999, February 29, 2000, February 20, 2001, September 1, 2001, and August 28, 2002.

Similarly, in the absence of any disagreement regarding the individual radiographic study, the following 25 chest x-rays are positive for pneumoconiosis: October 20, 1983, February 16, 1984, August 14, 1984, December 13, 1984, March 28, 1985, August 6, 1986, February 11, 1987, March 6, 1990, March 5, 1991, September 4, 1991, December 3, 1991, November 12, 1992, May 11, 1993, December 9, 1993, March 3, 1994, August 30, 1994, February 28, 1995, March 7, 1996, March 11, 1997, March 11, 1998, July 9, 1998, January 5, 1999, February 22, 1999, March 8, 1999, and March 17, 1999.

The physicians who reviewed the remaining 8 chest x-rays reached contrary conclusions. In the July 14, 1983 chest x-ray, Dr. Wheeler, a dual qualified radiologist, and Dr. Morgan and Dr. Gayler, both B readers, did not observe the presence of pneumoconiosis. Their consensus outweighs Dr. Cooper's positive interpretation. As a result, the July 14, 1983 chest film is negative for pneumoconiosis.

In the January 15, 2001 chest x-ray, Dr. Smiddy observed the presence of pneumoconiosis. However, three dual qualified radiologists, Dr. Wheeler, Dr. Scott, and Dr. Scatarige, disagreed and found no evidence of pneumoconiosis in the film. Two other B readers, Dr. Hippensteel and Dr. Castle, also found no evidence of black lung disease. Accordingly, based on the consensus of the better qualified physicians, I find the January 15, 2001 chest x-ray is negative for pneumoconiosis.

Two dual qualified radiologists, Dr. Pathak and Dr. Miller, found pneumoconiosis in the June 11, 2002 chest x-ray. Dr. Wiot, also a dual qualified radiologist, disagreed. Since all three physicians are similarly well qualified, I find the consensus of Dr. Pathak and Dr. Miller

outweighs Dr. Wiot's sole contrary opinion. The June 11, 2002 chest x-ray is positive for pneumoconiosis.

Dr. Baker, a B reader, saw pneumoconiosis in the chest x-ray from May 19, 2003. Dr. Wiot, a dual qualified radiologist did not see pneumoconiosis. Based on Dr. Wiot's better credentials, I give his opinion greater probative weight than Dr. Baker's reading of the same film.[30] As a result, the May 19, 2003 chest x-ray is negative for pneumoconiosis.

In the February 28, 1983 chest x-ray, Dr. Westerfield, a dual qualified radiologist, found the presence of pneumoconiosis. On the other hand, Dr. Wheeler, also a board certified radiologist and B reader, found the film negative for the presence of the disease. Although Dr. Morgan and Dr. Gayler, both B readers, agreed with Dr. Wheeler's assessment, Dr. Westerfield and Dr. Wheeler have superior credentials for the interpretation of chest films for pneumoconiosis. Their expert disagreement essentially renders the February 28, 1983 film inconclusive on the presence of pneumoconiosis.

Similarly, Dr. Westerfield and Dr. Wheeler disagreed on whether the April 11, 1983 film showed evidence of pneumoconiosis. Consequently, that radiographic evidence is inconclusive.

The two dual qualified radiologists to examine the chest x-ray of January 22, 2004 reached starkly contrasting interpretations. Dr. Alexander saw pneumoconiosis. Dr. Wiot did not. Since these two physicians are equally well qualified to assess radiographic evidence for pneumoconiosis, their interpretative standoff renders the January 22, 2004 chest x-ray inconclusive for the presence of pneumoconiosis.

Finally, the same type of interpretative show-down exists regarding the April 21, 2004 film. Dr. Ahmed found pneumoconiosis. Dr. Wiot did not see it. Since both physicians are dual qualified radiologists, their evenly split opinions also renders the April 21, 2004 film inconclusive for the presence of pneumoconiosis.

In summary, 33 (30 + 3) chest x-rays are negative for the presence of pneumoconiosis, 26 (25 +1) films are positive for black lung disease and 4 studies are inconclusive. Since the negative interpretations exceed the positive findings and even the most recent films remain either conflicted or inconclusive, the preponderance of the chest x-ray evidence is negative for coal workers' pneumoconiosis. Consequently, Mr. Edwards is unable to establish the presence of pneumoconiosis through radiographic evidence under 20 C.F.R. § 718. 202 (a)(1).

Medical Opinion

Although Mr. Edwards cannot establish the presence of black lung disease through chest x-ray evidence, he may still prove this requisite element of entitlement under 20 C.F.R. §

[30]The courts and Benefits Review Board have determined that it is proper to give greater probative weight to the interpretation of a dual qualified radiologist in comparison to a physician who is only a B reader. *Zeigler Coal Co. v. Director [Hawker]*, 326 F.3d 894 (7th Cir. 2003); *Cranor v. Peabody Coal Co*., 22 B.L.R. 1-1 (1999) (en banc on recon.) and *Sheckler v. Clinchfield Coal Co*., 7 B.L.R. 1-128 (1984).

718.202 (a) (4) through the preponderance of the more probative medical opinions. To better evaluate the diverse medical opinions, a review of the other objective medical evidence in the record is helpful.

Pulmonary Function Tests

Exhibit	**Date / Doctor**	**Age / Height**	**FEV_1 pre[31] post[32]**	**FVC pre post**	**MVV pre post**	**% FEV_1 / FVC pre post**	**Qualified[33] pre post**	**Comments**
DX 1	Feb. 3, 1983 Dr. Howland	50 72"`	1.74	2.53		69%	Yes[34]	(Hospitalization)
DX 1	Feb. 11, 1983 Dr. Smiddy	50 69"	2.36 2.16	3.01 3.02	67	78% 71%	No[35] No	(Invalid)[36]
DX 1	Jul. 25, 1983 Dr. Hippensteel	50 70"	2.73 2.55	3.72 3.39	97 95	73% 75%	No[37] No	
DX 1	Mar. 28, 1984 Dr. Abernathy	52 69"	3.50 3.50	4.06 4.27	103 111	86% 82%	No[38] No	
DX 1	Jul. 8, 1987 Dr. Smiddy	54 70"	3.09	4.13	92	75%	No[39]	Borderline obstruction
DX 1	Oct. 6, 1987 Dr. Endes-	54 69"	2.79 2.91	3.39 3.39	127 137	82% 86%	No[40]	

[31]Test result before administration of a bronchodilator.

[32]Test result following administration of a bronchodilator.

[33]Under 20 C.F.R. § 718.204 (b)(2)(i) (2001), to qualify for total disability based on pulmonary function tests, for a miner's age and height, the FEV1 must be equal to or less than the value in Appendix B, Table B1 of 20 C.F.R. § 718 (2001), **and either** the FVC has to be equal or less than the value in Table B3, or the MVV has to be equal **or** less than the value in Table B5, or the ratio FEV1/FVC has to be equal to or less than 55%.

[34]The qualifying FEV_1 number is 2.35 for age 50 and 72 inches; the corresponding qualifying FVC and MVV values are 2.94 and 94, respectively.

[35]The qualifying FEV_1 number is 2.13 for age 50 and 69 inches; the corresponding qualifying FVC and MVV values are 2.68 and 85, respectively.

[36]In Dr. Zaldivar's opinion, this study is invalid (DX 2).

[37]The qualifying FEV_1 number is 2.19 for age 50 and 70 inches; the corresponding qualifying FVC and MVV values are 2.76 and 88, respectively.

[38]The qualifying FEV_1 number is 2.10 for age 52 and 69 inches; the corresponding qualifying FVC and MVV values are 2.64 and 84, respectively.

[39]The qualifying FEV_1 number is 2.13 for age 54 and 70 inches; the corresponding qualifying FVC and MVV values are 2.69 and 85, respectively.

[40]The qualifying FEV_1 number is 2.06 for age 54 and 69 inches; the corresponding qualifying FVC and MVV values are 2.61 and 79, respectively.

	Bercher							
DX 2	Nov. 12, 1992 Dr. Smiddy	60 68”	2.30	3.62		63%	No[41]	
DX 2	Dec. 9, 1993 Dr. Smiddy	61 68”	2.46	3.65		67%	No[42]	
DX 2	Aug. 30, 1994 Dr. Smiddy	61 68”	2.45	3.95		62%	No	
DX 2	Jul. 26, 1996 Dr. Paranthaman	63 68.5”	2.16 2.29	3.82 3.55	76 82	56% 64%	No[43]	
DX 2	Jan. 16, 1997 Dr. Shipley	64 68”	2.10 2.60	3.68 3.86	58	57% 67%	No[44]	
DX 2	Mar. 11, 1997 Dr. Smiddy	64 68”	1.90 2.47	3.83 4.03		50% 61%	No No	
DX 2	Jul. 9, 1998 Dr. Smiddy	65 68”	2.35	3.85	77	61%	No[45]	(Possibly invalid)[46]
DX 2	Mar. 8, 1999 Dr. Smiddy	66 70”	2.22	3.69	52	60%	No[47]	
DX 2	Mar. 17, 1999 Dr. Smiddy	66 70”	1.94	3.12		62%	No	
DX 2	Apr. 30, 1999 Dr. Dahhan	66 68.1”	2.33 2.45	3.40 3.67	66	69% 67%	No[48] No	
DX 2	Feb. 29, 2000 Dr. McSharry	67 70”	1.94 2.09	2.80 3.10	65	69% 67%	No[49] No	

[41]The qualifying FEV_1 number is 1.87 for age 60 and 68 inches; the corresponding qualifying FVC and MVV values are 2.39 and 75, respectively.

[42]The qualifying FEV_1 number is 1.86 for age 61 and 68 inches; the corresponding qualifying FVC and MVV values are 2.37 and 74, respectively.

[43]The qualifying FEV_1 number is 1.89 for age 63 and 68.5 inches; the corresponding qualifying FVC and MVV values are 2.41 and 75, respectively.

[44]The qualifying FEV_1 number is 1.81 for age 64 and 68 inches; the corresponding qualifying FVC and MVV values are 2.32 and 72, respectively.

[45]The qualifying FEV_1 number is 1.79 for age 65 and 68 inches; the corresponding qualifying FVC and MVV values are 2.30 and 72, respectively.

[46]Upon review, Dr. Zaldivar and Dr. Renn disagreed on whether this study was valid. Dr. Zaldivar determined the test was valid; Dr. Renn disagreed.

[47]The qualifying FEV_1 number is 1.93 for age 66 and 70 inches; the corresponding qualifying FVC and MVV values are 2.48 and 77, respectively.

[48]The qualifying FEV_1 number is 1.81 for age 66 and 68.1 inches; the corresponding qualifying FVC and MVV values are 2.32 and 72, respectively.

[49]The qualifying FEV_1 number is 1.92 for age 67 and 70 inches; the corresponding qualifying FVC and MVV values are 2.46 and 77, respectively.

DX 2	Jan. 15, 2001 Dr. Smiddy	68 68"	2.03 1.98	3.43 3.21	47	59% 62%	No[50] No	(Possibly invalid)[51]
DX 2	Aug. 28, 2002 Dr. Castle	69 69"	1.94 1.99	3.22 3.44	41	60% 57%	No[52] No	

Arterial Blood Gas Studies

Exhibit	**Date / Doctor**	**$_pCO_2$ (rest) $_pCO_2$ (exercise)**	**$_pO_2$ (rest) $_pO_2$ (exercise)**	**Qualified**	**Comments**
DX 1	Feb. 3, 1983 Dr. Howland	40.1	70.8	No	(During hospitalization)
DX 1	Feb. 28, 1983 Dr. Smiddy	30.4	123	No[53]	(During hospitalization)
DX 1	Mar. 4, 1983 Dr. Smiddy	39.1	63.4	No[54]	
DX 1	Jul. 25, 1983 Dr. Hippensteel	35.6	72.7	No[55]	
DX 1	Mar. 28, 1984 Dr. Abernathy	32 24	52 78	Yes[56] No[57]	
DX 1	Jul. 8, 1987 Dr. Smiddy	39	72	No	
DX 1	Oct. 6, 1987 Dr. Endes-Bercher	36.2 33.3	74.3 83.8	No[58] No[59]	
DX 1	Nov. 1, 1987 Dr. Howland	39	64	No	
DX 1	Nov. 25, 1987 Dr. Faiz	33.6	56	Yes	(Hospitalization)

[50]The qualifying FEV_1 number is 1.74 for age 68 and 68 inches; the corresponding qualifying FVC and MVV values are 2.25 and 70, respectively.

[51]Upon review in February 25, 2002, Dr. Renn opined the pulmonary function test was invalid for several reasons, including absence of maximal effort, inconsistent rate of respiratory, and unsatisfactory MVV maneuvers (DX 2).

[52]The qualifying FEV_1 number is 1.82 for age 69 and 69 inches; the corresponding qualifying FVC and MVV values are 2.35 and 73, respectively.

[53]For a pCO^2 of 30, the qualifying pO^2 is 70, or less.

[54]For a pCO^2 of 39, the qualifying pO^2 is 61, or less.

[55]For a pCO^2 of 35, the qualifying pO^2 is 65, or less.

[56]For a pCO^2 of 32, the qualifying pO^2 is 68, or less.

[57]For a pCO^2 of 25 or below, the qualifying pO^2 is 75, or less.

[58]For a pCO^2 of 36, the qualifying pO^2 is 64, or less.

[59]For a pCO^2 of 33, the qualifying pO^2 is 67, or less.

DX 1	Nov. 26, 1987 Dr. Faiz	32	58	Yes	(Hospitalization)
DX 1	Nov. 27, 1987 Dr. Faiz	34	76	No[60]	(Hospitalization)
DX 1	Nov. 28, 1987 Dr. Faiz	36	69	No	(Hospitalization)
DX 1	Dec. 2, 1987 Dr. Faiz	40	77	No	(Hospitalization)
DX 1	Mar. 1, 1988 Dr. Taylor	39.4	61	Yes	(Hospitalization)
DX 1	May 17, 1988 Dr. Taylor	40.6	68.3	No	
DX 2	Jan. 2, 1992 (not named)	37.5	69	No	
DX 2	Jul. 26, 1996 Dr. Paranthaman	37	63	Yes	
DX 2	Jan. 16, 1997 Dr. Shipley	31	71	No[61]	
DX 2	Apr. 30, 1999 Dr. Dahhan	35.7	75.6	No	
DX 2	Feb. 2, 2000 Dr. McSharry	36	69	No	
DX 2	Aug. 28, 2002 Dr. Castle	34.9	62.8	Yes	Mild hypoxemia.

Medical Evaluations

Dr. Joseph F. Smiddy
(DX 1 and DX 2)

Between February 28 and March 2, 1983, Dr. Smiddy, board certified in internal medicine, hospitalized Mr. Edwards for evaluation of his breathing difficulties. Mr. Edwards had recently developed shortness of breath which he believed might be associated with the burning of metallic substances in the machine shop. Mr. Edwards reported a cigarette smoking history of 20 years. He had worked in coal mining for 10 years, with 6 years underground. He also reported some exposure to zinc. A chest x-ray showed old hilar granulamatous calcifications. A bronchoscopy exam revealed mild bronchitis.

Following an office visit in August 1983, Dr. Smiddy gave Mr. Edwards a letter indicating that he was totally disabled and unable to return to employment. According to Dr. Smiddy, chest x-rays showed a "significant degree" of pneumoconiosis and his oxygen blood level was "63."

On July 8, 1987, Dr. Smiddy again examined Mr. Edwards for severe shortness of breath. Dr. Smiddy noted his coal mine employment and indicated that Mr. Edwards "worked as a mechanic and the adjacent welding fumes which he was breathing produced severe breathing

[60]For a pCO^2 of 34, the qualifying pO^2 is 66, or less.

[61]For a pCO^2 of 31, the qualifying pO^2 is 69, or less.

difficulties." During the exam, Dr. Smiddy heard rales in both lungs. Although Mr. Edwards' pulmonary condition had improved since 1986, the pulmonary function test still showed a borderline obstruction and the arterial blood gas study indicated hypoxemia. The chest x-ray was positive for pneumoconiosis. Dr. Smiddy diagnosed chronic lung disease, old granulomatous lung disease, "and an additional element of coal workers' pneumoconiosis."

On June 13, 1996, Dr. Smiddy certified that Mr. Edwards was totally and permanently disabled due to "chronic obstructive pulmonary disease with old interstitial pulmonary fibrosis and scarring and underlying pneumoconiosis."

March 18, 1997, Dr. Smiddy again stated that Mr. Edwards was totally and permanently disabled due to a pulmonary impairment. The physician emphasized that Mr. Edwards was first diagnosed with pneumoconiosis in 1983 by chest x-ray. Subsequent chest x-ray interpretations confirmed its presence. Mr. Edwards' medical record covering 14 years shows "he has taken a large number of bronchodilator medications, home aerosols, and at one time, home oxygen." In Dr. Smiddy's opinion, Mr. Edwards has chronic obstructive pulmonary disease "with components of interstitial lung disease, asthma, bronchitis in addition to pneumoconiosis."

On January 5, 1999, Dr. Smiddy again examined Mr. Edwards who was "severely ill at times when off bronchodilators." The physical examination revealed decreased breath sounds. Mr. Edwards was using home oxygen at two liters per minute. He was 100% disabled and had "well documented pneumoconiosis." In February 1999, indicating Mr. Edwards should decline exercising blood gas testing, Dr. Smiddy indicated he was severely totally disabled by pulmonary disease.

On January 15, 2001, Dr. Smiddy examined Mr. Edwards as part of his follow-up care for pneumoconiosis and chronic bronchitis. The chest x-ray showed old pneumoconiosis. However, Mr. Edwards seemed to be doing well with his breathing medications. Dr. Smiddy diagnosed pneumoconiosis, COPD, and emphysema.

Dr. K.D. Taylor, II
(DX 1 and DX 2)

On May 17, 1983, Dr. Taylor examined Mr. Edwards. Mr. Edwards had smoked cigarettes for about 15 years and stopped in 1967. The physical examination disclosed diminished breath sounds. Mr. Edwards' PO_2 was 60. Dr. Taylor diagnosed chronic lung disease related to coal mine employment. In an August 8, 1983, Dr. Taylor added that Mr. Edwards was totally disabled, possibly permanently, due to a severe pulmonary disease.

From September 10, 1985 through May 17, 1988, Dr. Taylor periodically treated Mr. Edwards for bronchitis and bronchospasms. On occasions, he prescribed steroids as breathing medication.

Between March 1 and March 13, 1988, Dr. Taylor hospitalized Mr. Edwards for pneumonia. Upon admission, Mr. Edwards was experiencing progressively worsening shortness of breath and bronchospasms. Dr. Taylor heard diminished breath sounds and wheezing. Upon

discharge, Dr. Taylor diagnosed acute bronchitis due to pneumonia and exacerbation of COPD. A few weeks later, Dr. Taylor commented that Mr. Edwards has "far advanced pulmonary disease with fibrosis, emphysema, bronchospasms, and pneumoconiosis." In Dr. Taylor's opinion, Mr. Edwards was totally disabled by his breathing problems.

On March 19, 1997, Dr. Taylor noted that Mr. Edwards had been his patient for a number of years. Mr. Edwards had a history of coal dust exposure and struggled with a severe lung disease that was totally disabling. In his opinion, "it would be reasonable to assume that this is a cause and effect involved in this situation."

Dr. Kirk E. Hippensteel
(DX 1 and DX 2)

On July 25, 1983, Dr. Hippensteel examined Mr. Edwards, who worked nine years in coal mining until he left in February 1983 due to breathing problems. According to Dr. Hippensteel, Mr. Edwards reported "it was found that the welding area had some increase in chromium levels above those recommended as safe and this was discovered at about the time he developed breathing problems this last January." Mr. Edwards had smoked cigarettes for about 15 years at the rate of one pack per day. The chest x-ray was negative for pneumoconiosis. The arterial blood gas study showed mild hypoxemia. Dr. Hippensteel believed Mr. Edwards' pulmonary impairment was due to chromium irritation and not related to coal dust exposure. Since the breathing problem was treatable, Dr. Hippensteel did not believe Mr. Edwards' pulmonary disability was permanent.

On October 14, 1997, Dr. Hippensteel reviewed the medical record from 1983 through 1997. Dr. Hippensteel observed that Mr. Edwards' subjective distress did not correlate well with the objective medical evidence. Mr. Edwards did not have either a permanent pulmonary impairment or coal workers' pneumoconiosis. Even if coal workers' pneumoconiosis were present, it had not caused a permanent pulmonary impairment.

On June 15, 1999, Dr. Hippensteel considered the additional medical evidence developed through 1999 and concluded Mr. Edwards had not experienced any worsening of his pulmonary condition. Mr. Edwards did not have coal workers' pneumoconiosis or any coal dust related lung disease. He was not disabled from coal mine employment. Even if coal workers' pneumoconiosis were present in his lungs, Mr. Edwards had not suffered any pulmonary impairment from that disease.

On May 30, 2000, Dr. Hippensteel reviewed additional medical evidence developed through 2000. In his opinion, Mr. Edwards did not have coal workers' pneumoconiosis and was not totally disabled. Instead, Mr. Edwards has a partially reversible pulmonary impairment due to his asthma and cigarette smoking history. Even if coal workers' pneumoconiosis were present, his variable impairment is inconsistent with the airways impairment caused by pneumoconiosis.

On November 12, 2002, Dr. Hippensteel reviewed the new medical evaluations, tests, and radiographic interpretations developed since 2000. Despite some exceptions, the overall

radiographic record was "against coal workers' pneumoconiosis." Mr. Edwards has chronic asthmatic bronchitis unrelated to coal mine employment. His "mostly mild but variable lung function is not typical for that caused by coal workers' pneumoconiosis since coal workers' pneumoconiosis causes a fixed or progressive impairment rather than a variable and partly reversible impairment."

In a December 2, 2002 deposition, Dr. Hippensteel summarized his evaluations of Mr. Edwards' pulmonary condition and review of the medical record since 1983. The most recent pulmonary function test continued to show a mild airways obstruction. The oxygen level in the arterial blood gas study was "mildly" reduced and met the total disability thresholds. Nevertheless, Dr. Hippensteel did not believe Mr. Edwards was totally disabled from coal mine employment. The oxygenation problem could be due to non-pulmonary conditions. The reversibility of his airways obstruction points to the presence of asthma, which is unrelated to coal dust exposure. Dr. Hippensteel also interpreted four chest x-rays and found them negative for pneumoconiosis. Based on the extensive medical record, Dr. Hippensteel concluded Mr. Edwards does not have coal workers' pneumoconiosis or any lung disease related to coal dust exposure.

Dr. Robert Abernathy
(DX 1)

On March 28, 1984, Dr. Abernathy, board certified in internal medicine, evaluated Mr. Edwards' pulmonary condition. Mr. Edwards had worked nine years in coal mining; in his last job in the machine shop he welded. Mr. Edwards stopped working due to shortness of breath which he believed was related to his exposure to welding fumes. His cigarette smoking history was 14 pack years. Upon physical examination, Dr. Abernathy heard diminished breath sounds. The chest x-ray was negative for pneumoconiosis. The pulmonary function test was normal. With exercise, the arterial blood gas studies were satisfactory. Dr. Abernathy diagnosed a mild restrictive defect unrelated to coal dust exposure.

Dr. John S. Howland
(DX 1)

Between February 3 and February 8, 1983, Dr. Howland treated Mr. Edwards in the hospital for shortness of breath. Two weeks prior to admission, Mr. Edwards had become short of breath climbing the tipple at work. Since that incident he suffered shortness of breath upon exertion. Mr. Edwards had been in coal mining for ten years and smoked a pack of cigarettes a day for 20 years. Upon discharge, Dr. Howland diagnosed dyspnea possibly due to a restrictive airways disease.

Between November 1 and November 5, 1987, Dr. Howland hospitalized Mr. Edwards for treatment of his recent increasing respiratory distress. Mr. Edwards had a history of COPD, pneumoconiosis, and exposure to welding fumes. He was totally disabled by lung disease. Mr. Edwards had smoked cigarettes for 20 years at the rate of a pack a day. Upon examination, Dr. Howland heard bilateral wheezing. During the course of the hospital treatment, Mr. Edwards' wheezing resolved. Dr. Howland diagnosed acute asthma and COPD.

Dr. George Zaldivar
(DX 1 and DX 2)

On February 8, 1986, Dr. Zaldivar, board certified in internal medicine and pulmonary disease, reviewed Mr. Edwards' medical record since 1970 and numerous pulmonary evaluations conducted by Dr. Smiddy, Dr. Taylor, Dr. Hippensteel, and Dr. Abernathy, and the associated pulmonary testing and radiographic studies. Noting the most recent pulmonary function test was normal and the chest x-rays were negative, Dr. Zaldivar opined that Mr. Edwards "had no lung disease at all."

On February 4, 1988, Dr. Zaldivar reviewed additional medical records, including recent hospitalization treatment notes. Although the results had been varied, the most recent pulmonary function tests and exercise blood gas studies were normal. The preponderance of the radiographic evidence remained negative for pneumoconiosis. The record was too weak to support welding fumes as an etiology. Dr. Zaldivar opined Mr. Edwards did not have coal workers' pneumoconiosis and was not totally disabled.

In June 1988, Dr. Zaldivar reviewed the records from Mr. Edwards' hospitalizations. The additional evidence did not alter Dr. Zaldivar's opinion that Mr. Edwards did not have coal workers' pneumoconiosis and was not totally disabled. The physician once again noted the recent, normal pulmonary function tests. In Dr. Zaldivar's opinion, Mr. Edwards suffers "acute bronchial asthma during episodes of acute upper respiratory infection."

On October 10, 1997, Dr. Zaldivar reviewed additional medical evidence through 1997. The physician concluded insufficient medical evidence existed to justify a diagnosis of coal workers' pneumoconiosis. Mr. Edwards did not have a totally disabling pulmonary impairment. His variable pulmonary problems were due to asthma. Dr. Zaldivar noted, "When Mr. Edwards is in a stable condition taking his bronchodilator medication, [h]is breathing capacity is normal, revealing no pulmonary impairment whatsoever."

On June 8, 1999, Dr. Zaldivar reviewed additional medical evidence developed through May 1999, including the pulmonary examination by Dr. Dahhan and Dr. Smiddy's 1999 total disability determination. In Dr. Zaldivar's opinion, Mr. Edwards did not have coal workers' pneumoconiosis. Instead, he had a mild respiratory impairment which "is variable and due to asthma." From a pulmonary perspective, even if he had simple coal workers' pneumoconiosis, Mr. Edwards retained the capability to return to his former work as a coal miner.

On May 22, 2000, Dr. Zaldivar reviewed additional medical evidence through 2000, including Dr. McSharry's pulmonary examination. He remarked, "Mr. Edwards, who has had asthmatic symptoms for many years without any evidence of airways obstruction by previous breathing tests, by 1999, had developed airways obstruction of variable degree. At times it was mild and at times, moderate. At times, the obstruction was reversible, and at times, not." In most tests, the diffusion capacity was "normal" Additionally, he continued to be treated with bronchodilators. For these reasons, Dr. Zaldivar continued to diagnose asthma unrelated to coal mine employment. Mr. Edwards did not have coal workers' pneumoconiosis. He has pulmonary

impairment related entirely to his asthma. However, Mr. Edwards remained capable of returning to his last coal mine employment.

On November 12, 2002, Dr. Zaldivar reviewed additional medical evidence which indicated Mr. Edwards had begun to experience coronary artery disease and cerebrovascular accidents. In the past, he had also been hospitalized for acute exacerbation asthma. The majority of the B readers failed to find evidence of coal workers' pneumoconiosis in the chest x-rays. Mr. Edwards had a mild obstructive pulmonary impairment due to his asthma; it was unrelated to his coal mine employment.

Dr. Gregory Endes-Bercher
(DX 1)

On October 6, 1987, Dr. Endes-Bercher examined Mr. Edwards. Mr. Edwards had worked six years underground as a belt man and then worked as a mechanic. He smoked a pack of cigarettes a day for 16 years. Mr. Edwards complained about chronic shortness of breath since 1983. The physical examination of the chest and chest x-ray were normal. While Mr. Edwards experienced mild hypoxemia at rest, the exercise blood gas study was normal. The pulmonary function test revealed lung volume reduction associated with a mild restrictive lung disease. Dr. Endes-Bercher concluded Mr. Edwards did not have pneumoconiosis. Instead, Mr. Edwards struggled with asthmatic bronchitis; the restrictive impairment was associated with secretions within the lungs. Mr. Edwards was not totally disabled.

Dr. H. Faiz
(DX 1)

Between November 24 and December 2, 1987, Dr. Faiz treated Mr. Edwards in the hospital for abdominal pain and a gall bladder attack. During the course of the treatment, Mr. Edwards suffered bronchospasms. His arterial blood gas studies also improved and his lungs cleared. As part of the discharge diagnosis, Dr. Faiz indicated acute exacerbation of asthmatic bronchitis, and chronic obstructive pulmonary disease.

Dr. Gregory J. Fino
(DX 1 and DX 2)

On February 2, 1988, Dr. Fino, board certified in pulmonary disease and internal medicine, conducted an extensive medical record review. In the absence of definitive evidence, Dr. Fino discounted chromium exposure as a cause of Mr. Edwards' breathing problems. According to Dr. Fino, Mr. Edwards has asthma. This breathing condition is unrelated to coal dust exposure in part because of the condition's response to medication and bronchodilators; whereas, coal workers' pneumoconiosis is a "fixed lesion." Dr. Fino also noted that the preponderance of the radiographic evidence was negative for pneumoconiosis. Additionally, the more recent pulmonary tests showed that he does not have a pulmonary impairment.

On June 30, 1988, Dr. Fino reviewed the reports of Mr. Edwards' two hospitalizations. The additional reports did not change his previous conclusions. Mr. Edwards' hospital treatments

involved medication for asthma and he improved with that therapy. Dr. Fino stressed that coal workers' pneumoconiosis is not a reversible disease. The physician added, "The course of exacerbation and remissions as evidenced by this man's medical record clearly point to a reversible disease and no doubt that disease is asthma and not coal dust related." When Mr. Edwards' pulmonary condition was properly controlled, he had normal pulmonary function and was not totally disabled.

On October 13, 1997, Dr. Fino reviewed the medical record from 1983 through 1997. Based on his review, he still believed that while Mr. Edwards had asthma, he did not have any pulmonary condition related to his exposure to coal dust. When pneumoconiosis causes an obstruction, the fibrosis is significant; however, the majority of Mr. Edwards' chest x-ray interpretations were negative. Additionally, the reversibility associated with bronchodilator therapy "implies the cause of the obstruction is not fixed and permanent." Pneumoconiosis is a "fixed condition" such that "bronchodilator medication would be of no benefit." The variability in the arterial blood gas studies is consistent with asthma. Mr. Edwards was not totally disabled. He had "no more than a mild obstructive ventilatory abnormality due to asthma."

On June 7, 1999, Dr. Fino summarized the medical evidence developed since 1997 through 1999. Again, he concluded Mr. Edwards does not have coal workers' pneumoconiosis or any occupationally acquired pulmonary condition. He also is not totally disabled. In particular, based on the oxygen levels in the arterial blood gas studies, Dr. Fino also opined Mr. Edwards had no need for supplemental oxygen therapy. Mr. Edwards' mild respiratory impairment is secondary to asthma.

On May 23, 2000, after reviewing additional medical evidence, including Dr. McSharry's evaluation, Dr. Fino had no change to his previous conclusions. The new medical evidence continued to be consistent with Mr. Edwards' "variable lung disease – asthma," which was not attributable to his coal mine employment.

On November 14, 2002, after reviewing his prior evaluations from 1988 through 2000 and the most recent pulmonary examinations and medical tests, Dr. Fino indicated that he had not changed any of his opinions about Mr. Edwards' pulmonary condition.

Dr. S. K. Paranthaman
(DX 2)

On July 26, 1996, Dr. Paranthaman, board certified in pulmonary disease and internal medicine,[62] conducted a pulmonary evaluation of Mr. Edwards who worked in and around coal mines for 9 years and smoked cigarettes at the rate of a pack a day for 18 years. Mr. Edwards complained about chronic shortness of breath upon exertion. The chest physical examination and x-ray were normal. The pulmonary function test indicated a moderate impairment. The arterial blood gas study established total disability under the regulations. Dr. Paranthaman diagnosed COPD due to cigarette smoking. According to the physician, if Mr. Edwards had more than ten years of coal mine employment then coal dust may have aggravated his condition.

[62]I take judicial notice of Dr. Paranthaman's board certification and have attached the certification documentation.

Dr. Jeffrey Dale Sargent
(DX 2)

On January 16, 1997, Dr. Sargent, board certified in pulmonary and internal medicine, conducted a pulmonary examination. Mr. Edwards reported 9 years of employment in coal mining. He spent the last few years in that industry as a repairman and welder. His cigarette smoking history covered 15 years at one pack per day. Upon physical examination, Dr. Sargent heard crackles in the right lung base. The chest x-ray was negative for pneumoconiosis and the arterial blood gas study was normal. The pulmonary function tests indicated the presence of a completely reversible obstructive pulmonary impairment. Dr. Sargent concluded that Mr. Edwards did not have coal workers' pneumoconiosis. Observing that pneumoconiosis causes an irreversible, mixed obstructive/restrictive impairment, Dr. Sargent noted that Mr. Edwards' obstructive impairment was completely reversible and more consistent with asthma. Although Mr. Edwards retained the pulmonary capacity to return to his work as a repairman, Dr. Sargent believed his exposure to shop and welding fumes might irritate his asthma.

In a November 3, 1997 deposition, Dr. Sargent discussed his examination of Mr. Edwards and review of additional medical evidence. Dr. Sargent specifically disagreed with Dr. Taylor's stated assumption that a cause and effect existed between Mr. Edwards' exposure to coal dust and pulmonary condition. In Dr. Sargent's opinion, exposure to coal dust alone isn't a sufficient basis to diagnose coal workers' pneumoconiosis. Mr. Edwards had a mild cigarette smoking history. The chest x-ray was negative for pneumoconiosis and the arterial blood gas study was normal. The pulmonary function test showed an obstruction; however, upon use of bronchodilator, the "obstruction resolved completely." Coal workers' pneumoconiosis is not a reversible disease. Additionally, coal workers' pneumoconiosis causes a mixed obstructive and restrictive impairment. Mr. Edwards' breathing problem did not have a restrictive component. For these reasons, Mr. Edwards does not have coal workers' pneumoconiosis; he does not have a permanent pulmonary impairment. Instead, he struggles with asthma. The hospitalization records indicate treatment for asthma. Although coal dust can aggravate asthma, the associated impairment reverses after exposure ceases. Mr. Edwards does not have COPD, which is a non-reversible pulmonary condition.

Dr. James R. Castle
(DX 2)

On September 22, 1997, Dr. Castle, board certified in pulmonary disease and internal medicine, reviewed the medical record associated with Mr. Edwards' claim from 1983 through 1997, including pulmonary examinations, pulmonary tests, radiographic interpretations, and treatment notes by Dr. Smiddy and Dr. Taylor. Mr. Edwards had worked nine years as a coal miner with some underground exposure to coal dust. He smoked cigarettes for over 15 years. In Dr. Castle's opinion, Mr. Edwards did not have coal workers' pneumoconiosis. Mr. Edwards faced three pulmonary risks factors of coal dust, cigarette smoke, and bronchial asthma. Given the intermittent and reversible nature of Mr. Edwards' symptoms, Dr. Castle opined that bronchial asthma was the cause of his breathing problems. In particular, Dr. Castle noted the lack of radiographic evidence of pneumoconiosis and the mild reversible airways obstruction demonstrated by the pulmonary function tests. Additionally, the arterial blood tests were

generally normal; the intermittent results were inconsistent with the permanent damage caused by pneumoconiosis. Mr. Edwards also did not have a significant pulmonary impairment. Instead, he had a mild reversible airways obstruction related to bronchial asthma. Dr. Castle specifically disagreed with the total disability diagnoses by Dr. Smiddy and Dr. Taylor. He believed they were relying on subjective complaints. No physiological evidence of a pulmonary disability existed. According to Dr. Castle, the "most recent data would clearly indicate that this gentleman is essentially normal and does not have any disability whatsoever."

In a November 10, 1997 deposition, Dr. Castle reiterated his opinion that Mr. Edwards did not have any pulmonary impairment associated with his exposure to coal dust. In his opinion, Mr. Edwards has a "very mild degree of respiratory impairment, that when treated, or after bronchodilator, may return to totally normal." Mr. Edwards has bronchial asthma, an inflammatory airways disease. During an asthma attack, oxygenation levels in the blood can drop. Dr. Castle strongly disagreed with Dr. Smiddy's diagnosis of total disability. He emphasized that Dr. Smiddy's 1987 pulmonary function test of Mr. Edwards did not support a finding of total disability. Symptoms alone are an insufficient basis for a finding of total disability.

On June 14, 1999, Dr. Castle reviewed medical evidence developed from 1997 through 1999, including pulmonary evaluations and assessments by Dr. Smiddy and Dr. Dahhan. Based on the length of Mr. Edwards' coal mining, Dr. Castle questioned whether he had sufficient exposure to coal dust to develop coal workers' pneumoconiosis. His other two pulmonary risks factors, 15 to 17 pack years of cigarette smoking and bronchial asthma, are consistent with his reversible airways disease. Mr. Edwards is not totally disabled. Dr. Castle specifically challenged Dr. Smiddy's finding of 100% disability. He emphasized that Dr. Smiddy's pulmonary function tests showed only a mild obstruction and did not meet the disability threshold for the U.S. Department of Labor. In Dr. Castle's opinion, Dr. Smiddy was basing his disability diagnosis on "historical information alone."

On May 26, 2000, Dr. Castle reviewed additional medical evidence through 2000, including Dr. McSharry's examination. Based on his review, the physician continued to believe that Mr. Edwards did not have coal workers' pneumoconiosis. The pulmonary function test results continued to show a significant reversible degree of airways obstruction without a restrictive component or diffusion abnormalities. The test results were consistent with bronchial asthma and "totally inconsistent with a diagnosis of coal workers' pneumoconiosis" which would cause an irreversible ventilation defect. Mr. Edwards' mild degree of pulmonary obstruction is not totally disabling. Even if coal workers' pneumoconiosis were present, he is not disabled by that process.

On August 28, 2002, Dr. Castle conducted another pulmonary examination of Mr. Edwards. At that time, Mr. Edwards complained about shortness of breath upon exertion and used oxygen therapy at home. He had suffered a stroke and had unspecified heart problems. His reported cigarette smoking history amounted to 30 pack years. Mr. Edwards had worked in coal mining for a total of nine years. Upon physical examination, Dr. Castle heard distant breath sounds. The chest x-ray was negative for pneumoconiosis. The pulmonary function test showed a mild to moderate airways obstruction without a significant response to bronchodilators. The

arterial blood gas study indicated very mild hypoxemia. Based on this examination and a review of the medical record through 2002, Dr. Castle concluded Mr. Edwards did not have coal workers' pneumoconiosis. The majority of the chest x-ray interpretations were negative. The pulmonary function test results were variable and at time showed significant response to bronchodilators. The arterial blood gas studies also demonstrated variability in oxygenation levels. These varying test results were due to bronchial asthma.

Dr. Abdul K. Dahhan
(DX 2)

On April 30, 1999, Dr. Dahhan, board certified in pulmonary and internal medicine, conducted a pulmonary examination and reviewed the medical record from 1983 through November 1997. Mr. Edwards had 9 years of coal mine employment and a 17 pack year history of cigarette smoking. He complained about shortness of breath upon exertion. Upon physical examination, Dr. Dahhan heard a few scattered wheezes. The chest x-ray was negative for pneumoconiosis and the arterial blood gas study was normal. The pulmonary function test indicated the presence of a mild, partially reversible, obstructive pulmonary defect. Dr. Dahhan found insufficient evidence to diagnose coal workers' pneumoconiosis and total disability. He based his conclusion on: a normal clinical physical examination, variable airways obstruction responsive to bronchodilator therapy, normal lung volumes and diffusion, adequate arterial blood gas oxygenation, and a clear chest x-ray. Further, in light of the pulmonary function tests and arterial blood gas study, Mr. Edwards retained the physiological capacity to return to coal mine employment. Dr. Dahhan explained that Mr. Edwards' "mild variable ventilatory defect with persistent response to bronchodilator therapy . . . argues against it being due to coal dust exposure or coal workers' pneumoconiosis." His breathing problem was attributed to his previous cigarette smoking habit and contributed to by bronchial asthma.

In May 2000, Dr. Dahhan reviewed additional medical evidence developed through 2000. The physician still found the medical evidence insufficient to support a diagnosis of coal workers' pneumoconiosis. Mr. Edwards' airways obstruction had a variable response to bronchodilators which is inconsistent with the permanent adverse effect caused by coal dust on the respiratory system. Dr. Dahhan attributed Mr. Edwards' obstructive airways to his previous cigarette smoking history, hyperactive airways disease or bronchial asthma.

In an October 11, 2000 deposition, Dr. Dahhan again presented the results of his 1999 pulmonary evaluation of Mr. Edwards. Concerning Mr. Edwards' fifteen year cigarette smoking history, Dr. Dahhan acknowledged that he stopped smoking cigarettes 30 years ago. However, while quitting to smoke cigarettes prevents further acceleration of the lungs' deterioration, it does not repair the damage already done. Mr. Edwards' medications and therapies are used to dilate his bronchial tubes and reduce inflammation. The variations in the arterial blood gas studies and the pulmonary function studies are hallmarks "indicative of an individual who is suffering from bronchial asthma." Dr. Dahhan disagrees with Dr. Smiddy's diagnosis of total disability because the objective medical evidence doesn't support that determination. Based on the medical evidence from 1983 through May 2000, Dr. Dahhan concluded Mr. Edwards does not have either clinical or legal pneumoconiosis. His mild pulmonary impairment does not preclude his return to his last job in coal mining.

On November 1, 2002, Dr. Dahhan reviewed additional medical evidence produced through October 2002. In his opinion, no objective medical findings supported a diagnosis of coal workers' pneumoconiosis. In particular, the chest x-rays were generally negative, his obstructive pulmonary abnormality was variable, and he had normal lung diffusion and arterial blood gas mechanisms. Dr. Dahhan found no clinical or physiological evidence of total respiratory disability. Mr. Edwards' obstructive ventilatory defect was due to his prior cigarette smoking habit and possibly bronchial asthma.

Dr. Roger J. McSharry
(DX 2)

On February 29, 2000, Dr. McSharry, board certified in pulmonary and internal medicine, examined Mr. Edwards and reviewed the medical record since 1983. Mr. Edwards worked nine years in coal mining; he spent the last three years as a mechanic repairing belts and equipment. He had smoked cigarettes 15 to 16 years. Mr. Edwards complained about shortness of breath upon ambulation and daily wheezing. His present medication included puffers and occasional supplemental oxygen. Upon physical examination, Dr. McSharry heard some expired wheezes. The chest x-ray was negative for pneumoconiosis. The arterial blood gas study was essentially normal. The pulmonary function tests showed a mild to moderate obstructive lung disease with normal lung volume and diffusion and "without clear-cut bronchodilator responses." In Dr. McSharry's opinion, Mr. Edwards does not have coal workers' pneumoconiosis. Almost all of the radiographic interpretations were negative for pneumoconiosis. "Symptomatic coal workers' pneumoconiosis is almost universally associated with typical radiographic changes which being absent in this case makes symptomatic coal workers' pneumoconiosis extremely unlikely." Additionally, a notable aspect of Mr. Edwards' medical record was "evidence of variable obstructive disease which appears reversible with bronchodilator." However, with coal workers' pneumoconiosis, "no medication will improve respiratory function." Based on Mr. Edwards' symptoms and his stated breathing improvement with breathing medication, Dr. McSharry attributed the mild to moderate impairment to COPD with a significant asthmatic component. Though asthma can "transiently" worsened by dust or fumes, Mr. Edwards' present condition was not related to coal dust exposure which had ceased 17 years earlier. Based on Mr. Edwards' description of his mechanic work, Dr. McSharry did not believe the mild to moderate pulmonary obstruction would interfere with his return to that type of employment. Dr. McSharry specifically disagreed with Dr. Smiddy's disability finding because the objective medical evidence did not show a significant respiratory impairment due to a chronic lung disease. Even if Mr. Edwards had coal workers' pneumoconiosis, Dr. McSharry's conclusions would not change. The "only impairment noted is intermittent reversible obstructive lung disease, mainly asthma . . . not caused by coal dust or coal mine exposure."

In a November 10, 2000, Dr. McSharry indicated that he had reviewed additional medical evidence including Dr. Dahhan's recent pulmonary evaluation. The physician recalled that Mr. Edwards stated that his shortness of breath varied from day to day. That type of variability is a hallmark of reversible lung disease, such as asthma. Mr. Edwards' prescribed medication included inhaled steroids and oral bronchodilators which are used to treat asthma. The varying changes in Mr. Edwards' arterial blood gas studies are also indicative of an asthmatic. The results from the pulmonary function tests administered by Dr. McSharry did not indicate a

significant response to bronchodilator therapy. Rather than improvement ranging 12 to 15%, the test results improved only 8 to 11%. Pulmonary function tests a few years earlier showed marked improved of over 20%. As an explanation, Dr. McSharry indicated that on a bad day for an asthmatic, there may not be as much as a response from bronchodilator use. Additionally, Mr. Edwards' asthma may have been treated to the extent that the pre-bronchodilator levels were higher, thus raising the baseline. In Dr. McSharry's opinion, Mr. Edwards has fairly mild asthma and a mild pulmonary impairment. Since his last job as a coal miner only involved medium labor, Mr. Edwards is not totally disabled. At the same time, Mr. Edwards should avoid any further exposure to occupational dust and fumes. Mr. Edwards does not have either clinical or legal pneumoconiosis.

On November 21, 2002, Dr. McSharry reviewed additional medical evidence developed since 2000 and concluded Mr. Edwards had not experienced any change in his pulmonary condition. Dr. McSharry noted that numerous B readers found the chest x-rays negative for the presence of pneumoconiosis. The pulmonary function tests also did not produce typical findings of symptomatic coal workers' pneumoconiosis. Mr. Edwards' mild respiratory impairment was due to asthma.

Dr. Arthur M. Boyd
(DX 2)

On March 11, 2000, Dr. Boyd, board certified in family practice,[63] submitted a letter setting out his assessment of Mr. Edwards' pulmonary condition based on his treatment of Mr. Edwards since September 5, 1997. In Dr. Boyd's opinion, Mr. Edwards has severe asthmatic bronchitis and chronic pulmonary disease. The physician observed that Mr. Edwards "visits my office frequently in moderate to severe distress, although he is heavily medicated." He has received multiple treatments and been hospitalized several times for his lung problems. Intermittently oxygen dependent, Mr. Edwards is limited to an almost sedentary life. Mr. Edwards had been a coal miner from 1975 to 1983 and a pack a day cigarette smoker for 15 years. Mr. Edwards had admitted that he had asthma in the past. Dr. Boyd believed Mr. Edwards' breathing problems were in part related to his coal mine employment. The physician emphasized that "by history" Mr. Edwards was symptom-free prior to working in the mines.

On February 5, 2001, Dr. Boyd again indicated that Mr. Edwards has wheezing and a significant respiratory problem. Four to five times a year, Dr. Boyd treats Mr. Edwards for bronchitis "on top of his chronic impairment of his lungs." Mr. Edwards is chronically short of breath and has difficulty getting to the doctor's office. He is on maximum breathing medication and uses oxygen at home. Mr. Edwards has been fully evaluated by Dr. Smiddy, a pulmonologist, who has determined he is totally disabled. In Dr. Boyd's opinion, Mr. Edwards' pulmonary impairment is due in part to exposure to coal dust as a coal miner.

[63]I take judicial notice of Dr. Boyd's board certification and have attached the certification documentation.

Dr. Samuel V. Spagnolo
(DX 2)

In September 2000, Dr. Spagnolo, board certified in pulmonary disease and internal medicine, reviewed Mr. Edwards' medical record from 1983 through 2000. Mr. Edwards spent nine years working in the coal mines; in his last job, Mr. Edwards was a mechanic, repairing coal mine equipment. He had a 17 pack year history of cigarette smoking. His persistent complaints included shortness of breath upon exertion and intermittent wheezing. In Dr. Spagnolo's opinion, contrary to the conclusions of Dr. Smiddy and Dr. Taylor, the "overwhelming" medical evidence indicates that Mr. Edwards does not have any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment. Throughout the multiple pulmonary examinations, no consistent physical, laboratory, or radiographic findings indicative of coal workers' pneumoconiosis were produced. Specifically, "Mr. Edwards' medical history, physical findings, spirometry, blood gas results, chest radiographs, and his response to medication are virtually diagnostic of acute and chronic asthma." Based on the physical examination and pulmonary test results, Dr. Spagnolo concluded Mr. Edwards is capable of performing his prior coal mine employment.

On November 2, 2002, Dr. Spagnolo again reviewed the medical evidence from 1983 through October 2002. In his opinion, contrary to the conclusions by Dr. Smiddy and Dr. Taylor, Dr. Spagnolo indicated the medical evidence is "overwhelming that Mr. Edwards does not have any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment."

Discussion

The various physicians who evaluated, treated, or considered Mr. Edwards' pulmonary condition reached conflicting opinions on whether he has coal workers' pneumoconiosis. Dr. Howland, Dr. Taylor, Dr. Boyd, Dr. Baker, and Dr. Smiddy believed Mr. Edwards has black lung disease. Dr. Abernathy, Dr. Zaldivar, Dr. Endes-Bercher, Dr. Faiz, Dr. Fino, Dr. Paranthaman, Dr. Sargent, Dr. Dahhan, Dr. McSharry, Dr. Spagnolo, Dr. Castle, and Dr. Hippensteel concluded Mr. Edwards does not have coal workers' pneumoconiosis. Due to this conflict in medical opinion, I must first assess the relative probative value of each respective opinion in terms of documentation, reasoning, and medical qualifications.

Regarding the first probative value consideration, documentation, a physician's medical opinion is likely to be more comprehensive and probative if it is based on extensive objective medical documentation such as radiographic tests and physical examinations. *Hoffman v. B & G Construction Co.*, 8 B.L.R. 1-65 (1985). In other words, a doctor who considers an array of medical documentation that is both long (involving comprehensive testing) and deep (includes both the most recent medical information and past medical tests) is in a better position to present a more probative assessment than the physician who bases a diagnosis on a test or two and one encounter.

The second factor affecting relative probative value, reasoning, involves an evaluation of the connections a physician makes based on the documentation before him or her. A doctor's

reasoning that is both supported by objective medical tests and consistent with all the documentation in the record, is entitled to greater probative weight. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). Additionally, to be considered well reasoned, the physician's conclusion must be stated without equivocation or vagueness. *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988).

Third, a physician who is board-certified in the field of pulmonary disease and who has extensive experience in this area may be accorded greater deference because of his or her expertise. *Clark v. Karst-Robbins Coal Co.*, 12 BLR 1-149 (1989) (en banc); *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Burns v. Director, OWCP*, 7 BLR 1-597 (1984).

With these principles in mind, I first find Dr. Howland's opinion has diminished probative value since he only referenced that Mr. Edwards had a history of pneumoconiosis. Dr. Howland did not provide any reasoning about whether his hospitalization of Mr. Edwards in 1983 and 1987 supported a finding of pneumoconiosis. Instead, his discharge diagnosis was acute asthma and COPD. Additionally, since his last contact with Mr. Edwards occurred in 1987, Dr. Howland's documentation is limited.

Similarly, due to the dated and limited contact with Mr. Edwards, the opinions of Dr. Abernathy (1984), Dr. Endes-Bercher (1987), and Dr. Faiz (1987), Dr. Paranthaman (1997), and Dr. Sargent (1997) have less probative value on determining whether Mr. Edwards has now developed coal workers' pneumoconiosis.

Although Dr. Spagnolo reviewed the medical evidence from 1983 through 2000, his opinion loses some probative value due to a reasoning concern. In concluding the medical evidence is "overwhelming" against a diagnosis of pneumoconiosis, Dr. Spagnolo presents generalized statements without discussing how the objective medical test results enabled him to eliminate pneumoconiosis as a possible contributing cause of Mr. Edwards' pulmonary distress.

While Dr. Boyd treated Mr. Edwards for several years, his opinion that Mr. Edwards has pneumoconiosis suffers a reasoning shortfall because the principal basis for his diagnosis is simply Mr. Edwards' history of coal mine employment. According to Dr. Boyd, since Mr. Edwards was symptom-free prior to his coal mine employment, and subsequently struggled with disabling breathing problems, his impairment was due in part to coal dust exposure. Such reasoning falls well short in probative terms since Dr. Boyd failed to identify any aspect of the objective medical evidence that enabled him to isolate coal dust as a contributing factor.

As a treating physician between 1983 and 1997, Dr. Taylor was well positioned to render a probative assessment of Mr. Edwards' pulmonary condition. However, despite his familiarity with Mr. Edwards' breathing problems, his opinion has diminished probative weight for both documentation and reasoning problems. In terms of documentation, Dr. Taylor appears to have reviewed little of the extensive history of pulmonary function tests, arterial blood gas studies, and radiographic evidence. Within this extensive documentation is evidence of the variable, and at many times reversible, nature of Mr. Edwards' pulmonary obstruction and arterial oxygenation problem. The extensive record also demonstrates a significant and not inconsequential dispute on whether the chest x-rays establish the presence of documentation. Thus, since Dr. Taylor

apparently did not look much beyond his own treatment notes, his opinion is not particularly well documented.

Dr. Taylor's explanation for his diagnosis of pneumoconiosis also has a significant reasoning problem. Rather than explain how his treatment and evaluation of Mr. Edwards helped him isolate Mr. Edwards' pulmonary obstruction to pneumoconiosis, Dr. Taylor indicated that a reasonable assumption existed of a cause and effect relationship between his exposure to coal dust and lung disease. While such an assumption has understandable appeal, absent any additional explanation and considering Mr. Edwards' other two pulmonary risk factors of cigarette smoking and asthma, it is an insufficient rationale for a diagnosis of a lung disease attributable to coal dust exposure.

For two documentation shortfalls and a reasoning issue, Dr. Baker's opinion that Mr. Edwards has pneumoconiosis has diminished probative. First, Dr. Baker diagnosed medical pneumoconiosis principally based his own interpretation of the January 2003 chest x-ray as positive for pneumoconiosis. However, I determined that Dr. Wiot's interpretation of that film as negative has greater probative weight and that the preponderance of the radiographic evidence does not establish the presence of pneumoconiosis. Consequently, Dr. Baker's diagnosis of medical pneumoconiosis rests on inaccurate documentation.

Second, relying on the other aspects of his pulmonary examination of Mr. Edwards, Dr. Baker also diagnosed legal pneumoconiosis by indicating Mr. Edwards' COPD and bronchitis was in part due to his exposure to coal dust. That diagnosis rests on incomplete documentation because Dr. Baker did not conduct a post-bronchodilator pulmonary function test to determine whether Mr. Edwards' obstruction was reversible. As emphasized by Dr. Hippensteel and Dr. Castle, such a study is important to differentiate possible causes of a pulmonary obstruction. Notably, on many occasions the post-bronchodilator tests showed a response which is inconsistent with the permanent, irreversible damage associated with pneumoconiosis. Due to the absence of that test, Dr. Baker rendered his opinion without knowing that Mr. Edwards' pulmonary obstruction was partially reversible.

Third, Dr. Baker provided little reasoning for his determination that coal dust contributed to Mr. Edwards pulmonary obstruction. The physician did not identify any aspect of his pulmonary examination that helped him isolate coal dust as a contributing factor to Mr. Edwards' impairment.

In terms documentation, through long-term treatment and physician-patient contact, Dr. Smiddy was clearly very familiar with Mr. Edwards' breathing struggles for nearly 20 years. Although his personal interpretations of the chest x-rays are inconsistent with my determination that the preponderance of radiographic evidence does not establish the presence of pneumoconiosis, Dr. Smiddy certainly had sufficient other documentation consisting of clinical presentations, pulmonary tests, and response to medication upon which to rest his pulmonary diagnoses. Over the course of years, the treating physician identified asthma, pneumoconiosis, COPD, emphysema, and bronchitis as the lung diseases adversely affecting Mr. Edwards' ability to breathe normally.

In terms of reasoning, while Dr. Smiddy did not provide much elaboration, he identified physical examination results and pulmonary tests as a partial basis for his diagnoses. Although other physicians criticized Dr. Smiddy for diagnosing pneumoconiosis despite marked variability in pulmonary test results, I note that Dr. Smiddy did not just diagnose pneumoconiosis. Instead, he reasonably identified several co-existing lung problems, including asthma which the other physicians also diagnosed based on the response of Mr. Edwards' pulmonary obstruction to bronchodilators. Consequently, while not the best reasoned opinion in the record, Dr. Smiddy's conclusion that Mr. Edwards has pneumoconiosis retains probative value.

Though in a different capacity, Dr. Hippensteel has also followed Mr. Edwards' breathing problems for over 20 years, from his first pulmonary examination in July 1983 to his last evaluation in January 2004. While not a treating physician, Dr. Hippensteel has also been able to review the treatment notes of Dr. Smiddy, Dr. Taylor, and Dr. Boyd. Additionally, unlike the treating physicians, Dr. Hippensteel has also reviewed the other pulmonary function tests, arterial blood gas studies and radiographic interpretations associated with the several pulmonary examinations conducted by non-treating physicians. Relying on this extensive documentation basis, Dr. Hippensteel provided a well reasoned opinion that Mr. Edwards does not have coal workers' pneumoconiosis or any lung disease associated with exposure to coal dust. Based on the consideration that pneumoconiosis causes permanent and irreversible damage to the lungs, Dr. Hippensteel supported his elimination of pneumoconiosis as a pulmonary condition by noting that Mr. Edwards' pulmonary obstruction has not only varied throughout the years but continues to improve upon use of bronchodilator medication. The demonstrated variability and reversibility in the severity of Mr. Edwards' pulmonary obstruction are indicative of asthma and inconsistent with pneumoconiosis or a coal dust related pulmonary impairment.

Dr. Castle also based his reasoned assessment on a complete review of the objective medical evidence developed from 1983 through late 2004, coupled with pulmonary examinations in August 2002 and April 2004. In addressing the role Mr. Edwards' three pulmonary risk factors of coal dust, cigarette smoke, and bronchial asthma may have in the development of his obstructive impairment, Dr. Castle provided an in-depth rationale for his ability to differentiate and eliminate coal dust as a cause of Mr. Edwards' breathing difficulties. Well integrating all aspects of the objective pulmonary tests and radiographic evidence, Dr. Castle reasonably distinguished asthma, which produces varying breathing difficulties and responds to breathing medication, from the permanent and irreversible lung disease of pneumoconiosis, as the source of Mr. Edwards' breathing impairment.

The remaining board certified pulmonologists to consider Mr. Edwards' case also reached similar well documented and reasoned conclusions that Mr. Edwards does not have pneumoconiosis. Although their thorough consideration of Mr. Edwards' extensive medical record ended in 2002, Dr. Zaldivar, Dr. Fino, Dr. Dahhan, and Dr. McSharry all essentially focused on the same significant characteristics of Mr. Edwards' radiographic record and pulmonary tests which carried forward into 2004 and were highlighted by Dr. Hippensteel and Dr. Castle. The variation of the test results and the noted response to bronchodilator therapy identified bronchial asthma, rather than a coal dust related pulmonary disease, as the cause of Mr. Edwards' breathing problems.

Upon the conclusion of my probative assessment, I am left with the conflict between Dr. Smiddy's diagnosis of coal workers' pneumoconiosis and the contrary determinations by Dr. Zaldivar, Dr. Fino, Dr. Dahhan, Dr. McSharry, Dr. Hippensteel and Dr. Castle. Ultimately, in addition to recognizing the expertise associated with their board certifications in pulmonary disease/medicine, I find the consensus of Dr. Zaldivar, Dr. Fino, Dr. Dahhan, Dr. McSharry, Dr. Hippensteel, and Dr. Castle that Mr. Edwards does not have medical or legal pneumoconiosis outweighs Dr. Smiddy's finding of pneumoconiosis. Further, I find the opinions of Dr. Hippensteel and Dr. Castle are most consistent with all the objective medical evidence in the several thousand page record, including the preponderance of the radiographic interpretations, pulmonary function tests showing continued, varied, and at times significant, response to bronchodilators, and varying arterial blood gas studies. As a result, the preponderance of the more probative medical opinion evidence does not establish the presence of either legal or clinical pneumoconiosis. Accordingly, I find Mr. Edwards is not able to establish the presence of pneumoconiosis through the preponderance of the more probative medical opinions under 20 C.F.R. § 718.202 (a) (4).

Compton Consideration

As previously noted, the U.S. Court of Appeals for the Fourth Circuit requires consideration of the evidence together in the determination of whether pneumoconiosis is present. Since the preponderance of the radiographic evidence is negative for pneumoconiosis and the more probative medical opinion does not support a finding of pneumoconiosis, consideration of the evidentiary record as a whole fails to establish that Mr. Edwards has pneumoconiosis.

CONCLUSION

Through the preponderance of recent pulmonary function tests and medical opinions, Mr. Edwards has proven that he has become totally disabled due to a pulmonary impairment since December 2002, thereby establishing an element of entitlement previously adjudicated against him. However, upon consideration of the entire record, neither the preponderance of the radiographic evidence nor the more probative medical opinion establishes the presence of coal workers' pneumoconiosis in Mr. Edwards' lungs. As a result, Mr. Edwards has failed to prove the first requisite element of entitlement, the presence of pneumoconiosis, and his claim for disability benefits under the Act must be denied.

ORDER

The claim of MR. JAMES C. EDWARDS for benefits under the Act is **DENIED**.

SO ORDERED:

A

RICHARD T. STANSELL-GAMM
Administrative Law Judge

Date Signed: March 3, 2006
Washington, DC

NOTICE OF APPEAL RIGHTS: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. See 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. See 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board. After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed. At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. See 20 C.F.R. § 725.481. If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).

Attachment No. 1

American Board of Medical Specialties

Certification:

Glenn R. Baker, Jr., MD

Certified by the American Board of Internal Medicine in:

Internal Medicine and Pulmonary Disease

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://www.abms.org

Attachment No. 2

American Board of Medical Specialties

Certification:

Larry H. Westerfield, MD

Certified by the American Board of Nuclear Medicine in:

Nuclear Medicine

Certified by the American Board of Radiology in:

Diagnostic Radiology

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://www.abms.org

Attachment No. 3

American Board of Medical Specialties

Certification:

Subramaniam K. Paranthaman, MD

Certified by the American Board of Internal Medicine in:

Internal Medicine and Pulmonary Disease

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://www.abms.org

Attachment No. 4

American Board of Medical Specialties

Certification:

Arthur Morgan Boyd, MD

Certified by the American Board of Family Medicine in:

Family Medicine

American Board of Medical Specialties
1007 Church Street, Suite 404
Evanston, IL 60201-5913
Phone Verification: (866) ASK-ABMS
Phone: (847) 491-9091/FAX: (847) 328-3596

HTTP://www.abms.org